

Schedule of Findings and Questioned Costs
For the Fiscal Year Ended June 30, 2009

Federal Findings and Questioned Costs

09-01 The University of Washington did not have adequate internal controls to ensure accurate identification of its federal grant awards which resulted in misreporting of its federal grants expenditures.

Background

State agency management, the state Legislature and state and federal agencies rely on the information included in financial statements and reports to make decisions. It is the responsibility of University management to design and follow internal controls that provide reasonable assurance regarding the reliability of financial reporting. The control system must ensure that financial data is reliable, authorized, processed and reported.

Our audit identified a significant deficiency in controls that adversely affects the University's ability to produce reliable information needed to prepare the Schedule of Expenditures of Federal Awards (SEFA), which contains information that is a required element of the State of Washington Single Audit Report. This schedule is compiled by the state Office of Financial Management (OFM) based on information provided by each state agency. It is to be an accurate reporting of all federal expenditures by state agencies for each fiscal year. In addition to expenditure amounts, the SEFA must identify the federal granting agency and the Catalog of Federal Domestic Assistance (CFDA) program number for each award. Federal regulations make the grantee responsible for compliance with these requirements when the grant is accepted

Government Auditing Standards, prescribed by the Comptroller General of the United States, require the auditor to communicate significant deficiencies, as defined below in the Applicable Laws and Regulations section, as a finding.

Description of Condition

The University had \$881 million in federal expenditures in 2009 and \$848.8 million in 2008. We identified the following issues in our review of the federal expenditure information the University provided to OFM, that when taken together represents a significant deficiency in internal controls over financial reporting:

- During the preparation of the information for the 2008 SEFA, the Grant and Contract Accounting Office identified that two different CFDA numbers were included on the Notice of Grant Award (NGA) received from the federal agency for its AIDS Education and Training Centers program. Although receiving the federal award under two different CFDA numbers was identified as highly unusual, the University reported under both and did not take additional steps to follow through with the department or the federal agency to determine the correct CFDA number to report.
- The University performed a review and reconciliation of the federal expenditure information prepared by Grant and Contract Accounting. However, the review did not have a mechanism to identify and address unusual reporting, such as multiple CFDA numbers reported on the federal grant agreement.

Cause of Condition

The Grant and Contract Accounting Office did not follow through with the department or the sponsoring agency in 2008 to determine the correct CFDA number to report. The University's internal controls were insufficient to correct multiple CFDAs on the grant agreement received from the federal agency.

Effect of Condition and Questioned Costs

The SEFA is used for audit planning and grantor oversight. An incorrect SEFA can affect the amount of audit coverage required and can affect the selection of programs for audit. Further, an incorrect SEFA can delay an audit beyond the required nine-month reporting deadline and cause unnecessary audit costs.

The University reported federal expenditures under two program numbers when it should have only been one. The following was incorrectly reported on the 2008 SEFA:

- The Rapid Expansion of Antiretroviral Therapy/AIDS program (CFDA 93.266) reported \$26,478,068 in federal expenditures when it should have reported zero.
- The AIDS Education and Training Centers program (CFDA 93.145) reported \$5,906,838 in federal expenditures when it should have reported \$32,384,906.

Federal regulations detail how to identify programs to be audited using the SEFA. Due to the incorrect reporting by the University in 2008, a program required to be audited was not correctly identified. Additionally, the auditor was not provided the opportunity to consider the correct program for audit. We discovered the University's error during our fiscal year 2009 audit work. We initially selected CFDA 93.266 for audit based on the federal criteria; however, we later determined the expenditures were misreported and had to alter our audit plan. As a result, we determined the reporting error was related to fiscal year 2008.

The deficiencies in internal controls make it reasonably possible that more significant misstatements could occur and not be prevented or detected by the University future years.

Recommendation

We recommend the University communicate with its departments and sponsoring agencies when contradictory award information is received to ensure federal requirements are met and information is accurately reported.

We further recommend the University ensure a sufficiently detailed review and reconciliation of the federal expenditure information needed to prepare the SEFA is performed prior to submission to the Office Financial Management.

University's Response

The University agrees with the recommendation and has already implemented improvements as a result of this issue.

It is important to reiterate that the error related to the classification of expense within a single report produced in 2008. Total federal expenditures were correctly reported. The issue was identified and resolved in 2009 and was reflected in the accurate submission of this particular report in 2009.

As is evident in the description of the finding, this was an extremely unique situation. Once the issue was discovered in 2009, the University spent several months trying to obtain clarification as to which CFDA number was to be reported. The University contacted the funding agency numerous times before our questions were satisfactorily answered. The University's controls have always been strong in the area of grant reporting, however, they did not contemplate a multiple CFDA reference like this as it had never occurred before.

However, as a result of this issue, the University is training its staff on the difference between the funding and the program CFDA and directing them to pay attention to awards with multiple CFDA numbers. Staff will also continue to communicate with campus departments and the applicable agency when discrepancies are identified to ensure federal requirements are met and information is accurately reported.

Auditor's Concluding Remarks

We appreciate the University's commitment to resolve this finding and thank the University for its cooperation and assistance during the audit. We will review the corrective action taken during our next regular audit.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 300 states in part:

The auditee shall:

- (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.
- (c) Comply with laws, regulations, and the provisions of contracts or grant agreements related to each of its Federal programs.
- (d) Prepare appropriate financial statements, including the schedule of expenditures of Federal awards in accordance with § ____.310.

U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 520 states in part:

Major program determination:

(b) Step 1

- (1) The auditor shall identify the larger Federal programs, which shall be labeled Type A programs. Type A programs are defined as Federal programs with Federal awards expended during the audit period exceeding the larger of...:

- (iii) \$30 million or 15 hundredths of one percent (.0015) of total Federal awards expended in the case of an auditee for which total Federal awards expended exceed \$10 billion.

(e) Step 4 At a minimum, the auditor shall audit all of the following as major programs:

- (1) All Type A programs, except the auditor may exclude any Type A programs identified as low-risk under Step 2 (paragraph (c)(1) of this section).

Government Auditing Standards, January 2007 Revision - Section 5.11 states:

For all financial audits, auditors should report the following deficiencies in internal control:

- a. Significant deficiency: a deficiency in internal control, or combination of deficiencies, that adversely affects the entity's ability to initiate, authorize, record, process or report financial data reliably in accordance with generally accepted accounting principles such that there is a more than remote likelihood that a misstatement of the entity's financial statements that is more than inconsequential will not be prevented or detected.

State Administrative and Accounting Manual section 50.30.45 – Responsibilities of state agencies/institutions administering or expending federal awards

- (2) Identify, account for, and report all expenditures of federal awards in accordance with laws, regulations, contract and grant agreements, and requirements included in this and other sections of the OFM, *State Administrative and Accounting* manual.

State Administrative and Accounting Manual section 95.20.10 – Federal Assistance Disclosure Reporting Structure

Each state agency or institution that expends awards of federal assistance during a state fiscal year must complete federal disclosure forms. To meet federal reporting requirements, agencies must report all federal assistance received, disbursed, and/or on hand and must complete the Federal Assistance Certification form. Both the agency head and chief financial officer are to certify, to the best of their knowledge, that the agency complied with federal assistance requirements and that the information reported by the agency is complete and accurate.

09-02 The Department of Social and Health Services is not complying with federal requirements for allocating employee leave buyouts.

Federal Awarding Agency: U.S. Department of Agriculture
U.S. Justice Department
U.S. Department of Health and Human Services

Pass-Through Entity: None

CFDA Number and Title: 10.551,.561 Supplemental Nutrition Assistance Cluster
10.551,.561 Supplemental Nutrition Assistance Cluster –
American Recovery and Reinvestment Act
(ARRA)
16.540 Juvenile Justice & Delinquency Prevention Grant
93.243 Substance Abuse and Mental Health Services
93.563 Child Support Enforcement
93.563 Child Support Enforcement - ARRA
93.658 Foster Care Title IV-E
93.658 Foster Care Title IV-E - ARRA
93.778,.775,.777 Medical Assistance Cluster
93.778,.775,.777 Medical Assistance Cluster - ARRA

Federal Award Number: Multiple

Applicable Compliance Component: Allowable Costs/Cost Principles

Questioned Cost Amount: \$152,159

Background

Federal regulations require the Department of Social and Health Services to prepare and administer a Public Assistance Cost Allocation Plan. The Plan must describe procedures the Department uses to identify, measure and allocate all direct and indirect costs to each program it administers. The Plan must be approved by the grantors.

The plan must include all agency costs charged to federal awards, except those for financial assistance to recipients, medical vendor payments and costs for services and goods provided directly to program recipients.

Cost allocation bases are used to accumulate and distribute administrative costs to the benefitting federal programs. These distributions may be based on caseloads, number of employees, employee time and activity reports or other reasonable criteria.

An administrative cost is eligible for federal reimbursement only if the methodology used to account for and claim the cost is clearly identified as part of an approved Plan.

The Department’s Financial Services Administration, Office of Accounting Services (OAS) is responsible for developing and administering the Plan.

The Plan requires the agency to charge all employee vacation and sick leave buyouts (for terminations or retirees) to the termination leave base, which spreads the cost across all agency programs and funding sources. The agency initially charges termination leave to an employee’s current funding source(s). One to three months later, OAS transfers the accumulated leave buyout costs to the leave base effectively removing the charges from the previously charged federal grant(s) or allocation base(s).

Description of Condition

The Department claimed federal reimbursement for employee leave buyouts that did not comply with the methodologies in its approved Plan.

When the Department prepared its termination leave transfer for July through September 2008, it did not transfer prior biennium costs that were paid in the same period. These costs represented prior biennium expenditures accrued in June 2008 that were not actually paid until July and August of 2008.

Cause of Condition

OAS stated the Department transfers only current expenditures to its termination leave base. OAS staff did not understand they also had to transfer the costs from the prior biennium and did not include them in the leave transfer for the period in question.

Effect of Condition and Questioned Costs

When a public assistance agency charges federal programs outside of the methods approved in the Plan, federal grantors cannot be assured costs allocated to programs are accurate and valid.

We are questioning the following costs because they were not allocated correctly through the leave termination base, but were charged directly to federal programs or allocated through cost allocation bases to various federal programs.

Questioned Costs by CFDA for July and September 2008:

	Federal Share	State Share	Totals
Medicaid Cluster	\$ 29,203	\$29,203	\$ 58,406
Foster Care Title IV-E	\$ 12,287	\$12,287	\$ 24,574
Child Support Enforcement	\$12,337	\$ 6,355	\$ 18,692
Substance Abuse and Mental Health Services	\$30,213	\$ 0	\$ 30,213
Food Stamp Cluster	\$ 5,599	\$ 5,599	\$ 11,198
Juvenile Justice & Delinquency Prevention Grant	\$ 4,538	\$ 4,538	\$ 9,076
			\$ 152,159

Recommendations

We recommend the Department:

1. Establish procedures to ensure all agency termination leave and associated Social Security and Medicare costs are appropriately allocated through the termination leave base consistent with the approved Public Assistance Cost Allocation Plan.
2. The Department should consult with its grantor to determine what, if any, of the questioned costs should be repaid

Department's Response

The Department concurs with this finding. During 2009, DSHS appropriately transferred slightly over \$4.1 million to the terminal leave base. Because the staff that were learning the transfer process relied upon procedures that did not adequately or completely describe the transfer requirements, the 2009 liquidation portion of the prior year terminal leave charges was inadvertently not transferred. The liquidation portion represents about 8% of the total termination leave charges for 2009.

The Office of Accounting Services is updating the procedures to reflect all parts of the termination leave transfer. As SAO stated, DSHS has followed the correct practice for the fiscal year 2010 termination leave transfers. The SAO identified questioned costs of \$152,159. The Department will request that Health and Human Services (HHS) confer with the granting entity during the federal clearing house audit process. The granting entity will determine and notify DSHS whether repayment is required.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable laws and Regulations

Title 45 Code of Federal Regulations, Subtitle A (10-1-03 Edition), Section 95.507 - Plan Requirements, sub-section (b.8) states in part:

. . . an adequate accounting and statistical system exists to support claims that will be made under the cost allocation plan.

Plan requirements.

- (a) The State shall submit a cost allocation plan for the State agency as required below to the Director, Division of Cost Allocation (DCA), in the appropriate HHS Regional Office. The plan shall:
 - (1) Describe the procedures used to identify, measure, and allocate all costs to each of the programs operated by the State agency...
 - (b) (4) The procedures used to identify, measure, and allocate all costs to each benefiting program and activity (including activities subject to different rates of FFP).

Section 95.517 - Claims for Federal Financial Participation, sub-section (a) states in part:

A State must claim FFP for costs associated with a program only in accordance with its approved cost allocation plan.

The U.S. Office of Management and Budget's Circular A-87, Cost Principles for State, Local and Indian Tribal governments provides in:

Attachment A, Section C.3 of the Circular requires allocable costs to be chargeable or assignable in accordance with the relative benefits received.

The Washington State Approved Cost Allocation Plan in effect for the 2007-2009 biennium states in part:

“Termination Leave – Payments for unused leave when an employee retires or terminates employment are allocated as a general administrative expense to all activities of DSHS. Costs are incurred for both annual and sick leave. Expenses are

Ø Allocated through the Agency Leave Termination Base...”

09-03 The Recreation and Conservation Office is not in compliance with federal cash management requirements.

Federal Awarding Agency: U.S. Department of Commerce
Pass-Through Entity: Washington State Recreation and Conservation Office
CFDA Number and Title: 11.438 Pacific Coast Salmon Recovery
Federal Award Number: NA03NMF4380227, NA04NMF4380260, NA05NMF4381269, NA06NMF4380091, NA07NMF4380301, NA08NMF4380608
Applicable Compliance Component: Cash Management
Questioned Cost Amount: Unknown

Background

The Recreation and Conservation Office received more than \$17 million in federal funds from the U.S. Department of Commerce for salmon recovery efforts during fiscal year 2009. It passed approximately 97 percent of this money on to subrecipients such as cities, towns, counties, state agencies, special-purpose districts, non-profit organizations, Indian tribes and private landowners to fund approved projects.

Grant regulations allow the Office to receive cash advances if the money is spent within 30 days. This ensures the funds are immediately put to use and prevents recipients from using the funds to generate interest income. Federal regulations further require the Office to ensure cash draws by subgrantees “conform substantially to the same standards of timing and amount” as apply to the Office. This means the Office must monitor cash advances to subrecipients to ensure it is providing funding only to meet immediate needs and must ensure the money is spent in a timely manner.

Description of Condition

The Office’s cash advance activity does not substantially conform to the 30-day requirement. We reviewed the Office’s grant agreements with its subrecipients. The Office has a policy that allows subrecipients to receive cash advance funds to cover 90 days of anticipated expenses. In addition, subrecipients have 120 days to provide documentation of how these cash advanced funds were spent.

<u>Number of Days Outstanding</u>	<u>Number of Advances</u>	<u>Dollar Amounts Outstanding</u>
31-60	24	\$1,322,595
61-90	27	\$2,463,814
91-120	19	\$2,165,386
Over 120	6	\$260,594
Total	76	\$6,212,389

We noted many instances in which subrecipients were allowed more than 120 days before providing supporting documentation to show the funds were expensed.

We reviewed the documentation provided and found it did not show when, or even if, the money was spent. The Office neither requires nor receives copies of paid invoices or other documents to show federal funds were paid out in a timely manner. We reported concerns with the Office’s overall monitoring of subrecipient activity in finding 09-04.

Cause of Condition

The Office was unaware that its policy and practices were not in compliance with the federal regulations for cash advances.

Effect of Condition

The Office is not ensuring that federal grant funds are being put to immediate use. Funds not immediately used are neither earning interest for the federal government nor are they available for use by others eligible to receive them. The state may be required to reimburse the federal government its share of interest lost due to delays in the use of funds. Additionally, this could jeopardize future federal funding.

Recommendations

We recommend the Office revise its policies and procedures to substantially conform to the federal government's requirements to limit cash advances to the minimum funds needed for 30 days. In addition, we recommend the Office require subrecipients to provide timely documentation of expenditures.

The Office should consult with its grantor to determine if interest is due to the grantor.

Office's Response

We thank the auditor for their review of RCO processes and files. RCO takes the stewardship of funds seriously. Review of RCO accounting practices by the SAO is just one way we ensure that the agency appropriately uses grant funds.

Cash Advances have been a key component of our salmon recovery grant making process since the beginning of the program. When the program began our current approach was discussed and agreed upon with our federal funding partner and accepted, including the 90 and 120 day thresholds. Unfortunately this agreement was not memorialized in the funding agreements.

We are aware that the agreement with the federal government states a limit of 30 days but we communicated with our federal grants administrator and were told this process was acceptable. We recently revisited this agreement with the federal government and NOAA staff reiterated their approval of our process, including the 90 and 120 day thresholds.

RCO staff will request a formal amendment to our federal agreements that clearly spells out the RCO advance process. As part of our corrective action plan, RCO staff will review the RCO advance process. RCO staff will also issue communications to the sub-recipients that outline the requirements of the RCO advance policy.

Auditor's Concluding Remarks

We thank the Office for its cooperation and assistance throughout the audit. We will review the status of the Office's corrective action during our next audit.

Applicable Laws & Regulations

The Cash Management Improvement Act section 8.6.1 states in part:

The State shall be liable for interest on Federal funds from the date Federal funds are credited to a State account until the date those funds are paid out for program purposes.

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 300, states in part:

The auditee shall:

- (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.

Title 15 Code of Federal Regulations, Part 24, Section 20 outlines responsibilities for entities receiving federal funds and states in part:

- (7) Cash management. Procedures for minimizing the time elapsing between the transfer of funds from the U.S. Treasury and disbursement by grantees and subgrantees must be followed whenever advance payment procedures are used. Grantees must establish reasonable procedures to ensure the receipt of reports on subgrantees' cash balances and cash disbursements in sufficient time to enable them to prepare complete and accurate cash transactions reports to the awarding agency. When advances are made by letter-of-credit or electronic transfer of funds methods, the grantee must make drawdowns as close as possible to the time of making disbursements. Grantees must monitor cash drawdowns by their subgrantees to assure that they conform substantially to the same standards of timing and amount as apply to advances to the grantees.

Title 15 Code of Federal Regulations, Part 24, Section 21 outlines responsibilities for entities receiving federal funds and states in part:

- (i) Interest earned on advances. Except for interest earned on advances of funds exempt under the Intergovernmental Cooperation Act (31 U.S.C. 6501 et seq.) and the Indian Self-Determination Act (23 U.S.C. 450), grantees and subgrantees shall promptly, but at least quarterly, remit interest earned on advances to the Federal agency. The grantee or subgrantee may keep interest amounts up to \$100 per year for administrative expenses.

United States Department of Commerce, Financial Assistance Standard Terms and Conditions outlines responsibilities for entities receiving federal funds and states in part:

A. Financial Requirements

.02 Award Payments

- d. Advances shall be limited to the minimum amounts necessary to meet immediate disbursement needs, but in no case should advances exceed the amount of cash required for a 30-day period. Advanced funds not disbursed in a timely manner and any applicable interest must be promptly returned to DOC.

J. Code of Conduct and Subaward, Contract, and Subcontract Provisions

.02 Applicability of Award Provisions to Subrecipients

- a. The recipient shall require all subrecipients, including lower tier subrecipients, under the award to comply with the provisions of the award, including applicable cost principles, administrative, and audit requirements.

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, outlines responsibilities for pass-through entities receiving federal funds and states in part:

Subsection D – Federal Agencies and Pass-Through Entities

400(d) Pass-through entity responsibilities:

A pass-through entity shall perform the following for the Federal awards it makes:

- (1) Identify Federal awards made by informing each subrecipient of CFDA title and number, award name and number, award year, if the award is R&D, and name of Federal agency. When some of this information is not available, the pass-through entity shall provide the best information available to describe the Federal award.
- (2) Advise subrecipients of requirements imposed on them by Federal laws, regulations, and the provisions of contracts or grant agreements as well as any supplemental requirements imposed by the pass-through entity.

- (3) Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and those performance goals are achieved.
- (4) Ensure that subrecipients expending \$300,000 (\$500,000 for fiscal years ending after December 31, 2003) or more in Federal awards during the subrecipient's fiscal year have met the audit requirements of this part for that fiscal year.
- (5) Issue a management decision on audit findings within six months after receipt of the subrecipient's audit report and ensure that the subrecipient takes appropriate and timely corrective action.
- (6) Consider whether subrecipient audits necessitate adjustment of the pass-through entity's own records.
- (7) Require each subrecipient to permit the pass-through entity and auditors to have access to the records and financial statements as necessary for the pass-through entity to comply with this part.

09-04 The Recreation and Conservation Office does not have adequate internal controls over sub-recipient monitoring.

Federal Awarding Agency:	U.S. Department of Commerce
Pass-Through Entity:	Washington State Recreation and Conservation Office
CFDA Number and Title:	11.438 Pacific Coast Salmon Recovery
Federal Award Number:	NA03NMF4380227, NA04NMF4380260, NA05NMF4381269, NA06NMF4380091, NA07NMF4380301, NA08NMF4380608
Applicable Compliance Component:	Subrecipient Monitoring
Questioned Cost Amount:	None

Background

The Recreation and Conservation Office received more than \$17 million in federal funds from the U.S. Department of Commerce for salmon recovery efforts during fiscal year 2009. Approximately 97 percent of this money is passed on to subrecipients such as cities, towns, counties, state agencies, special-purpose districts, non-profit organizations, Indian tribes and private landowners. Projects frequently take several years to complete. Federal regulations require the Office to monitor subrecipients to ensure they comply with grant conditions.

During the fiscal year 2007 and 2008 audits, we reported the Office did not adequately monitor subrecipients.

Description of Condition

We reviewed the Office's corrective action plan and found no improvements had been made since our last audit. Subrecipient monitoring still is inadequate.

Allowable costs/cost principles

Pass-through entities are to provide reasonable assurance that the costs of goods and services charged to federal awards are allowable and charged in accordance with regulations. While the Office reviews subrecipients' costs for allowability prior to reimbursement, it does not require documentation such as receipts, invoices or timesheets. Although certain costs are allowable, the Office requires only a check number or a term such as "payroll" as documentation.

We also found compensating controls were not operating as designed. The Office does not regularly inspect project sites or review subrecipients' financial records. As a result of the prior year finding, the Office stated it would do an analysis of subrecipients to help determine the level of monitoring required. The Office has not done so.

Earmarking

Subrecipients are allowed to use a percentage of grant funds for administrative costs related to the grant. Pass-through entities are to provide reasonable assurance that only allowable costs that are properly calculated and valued are included in these costs. We could not determine whether these requirements were met due to the inadequacy of supporting documentation.

Cause of Condition

Office management believed the documentation it receives is sufficient evidence of allowability. In addition, Office management did not allocate adequate resources to review subrecipients' financial records or perform an analysis of subrecipients as outlined in its corrective action plan.

Effect of Condition

The Office cannot ensure that costs reimbursed to subrecipients are accurate or allowable. Because the Office distributes grant money to non-profits, tribes and private landowners who are not required to have an audit unless their federal expenditures are \$500,000 or more, the risk of non-compliance is increased. In calendar year 2008, the Office provided federal funding to at least 60 subrecipients who were not required to have an audit. The Office

spent more than \$17 million of Pacific Coast Salmon Recovery grant funds in fiscal year 2009. Due to the lack of supporting documentation, it was not possible to determine if these costs were allowable.

Recommendations

We recommend the Office establish and follow policies and procedures to effectively monitor subrecipients' use of federal funds. The Office should require documentation such as receipts and invoices and/or establish adequate compensating controls to ensure all costs are allowable and in accordance with federal restrictions.

Office's Response

We thank the auditor for their review of RCO processes and files. RCO takes the stewardship of any funds seriously. Review of RCO accounting practices by the SAO is just one way we ensure that the agency is appropriately using grant funds.

Since the last audit was finalized a key staff member moved on to a new opportunity. This vacancy in the fiscal office negatively impacted RCO's sub-recipient monitoring. This vacancy lasted six months due to the 2009 statewide hiring freeze, not because we did not allocate adequate resources. With the vacancy, it was a challenge to accomplish the remaining workload. As a result many of the initiatives identified at the conclusion of the last audit were not achieved until after the fiscal year.

The SAO recommends requiring documentation or establishing adequate compensating controls to ensure costs are allowable. We researched our options and found that many agencies do not require copies of all documentation, but use compensating controls to verify costs are allowable. Similar to these other agencies, RCO will improve our process by developing and using compensating controls. Each sponsor will be subject to a risk assessment and either an A-133 audit done by an independent auditor or, if determined to be high risk, a, sub-recipient fiscal review. This new process is starting in late February 2010. High risk sponsors (based on the risk assessment) will be required to submit photocopies of all detailed backup materials. Some of these high risk sponsors will receive an in-office visit from RCO staff.

It is important to note that all projects are inspected, documented and reported on throughout the life of the project. RCO makes sure that every project accomplishes its goals. All invoices include summarized details and are reviewed for eligibility and appropriateness before any payment is made. The standardized invoice voucher includes the standard certification statement from the state invoice form (A-19) stating that the charges are proper charges.

RCO's long term goals involve updating our grant reimbursement process to allow electronic billing and performance-based contracting. We need to work together to find new ways to maintain our financial stewardship obligations while continuing our efforts to implement the state's goals on sustainability. Requiring sub-recipients to copy and mail thousands of individual receipts, invoices and timesheet will take more effort and natural resources. Copying and mailing individual receipts will be required in certain circumstances.

Auditor's Concluding Remarks

We thank the Office for its cooperation and assistance throughout the audit. We will review the status of the Office's corrective action during our next audit.

Applicable Laws & Regulations

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 300, states in part:

The auditee shall:

- (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.

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400(d) Pass-through entity responsibilities:

A pass-through entity shall perform the following for the Federal awards it makes:

- (1) Identify Federal awards made by informing each subrecipient of CFDA title and number, award name and number, award year, if the award is R&D, and name of Federal agency. When some of this information is not available, the pass-through entity shall provide the best information available to describe the Federal award.
- (2) Advise subrecipients of requirements imposed on them by Federal laws, regulations, and the provisions of contracts or grant agreements as well as any supplemental requirements imposed by the pass-through entity.
- (3) Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and those performance goals are achieved.
- (4) Ensure that subrecipients expending \$300,000 (\$500,000 for fiscal years ending after December 31, 2003) or more in Federal awards during the subrecipient's fiscal year have met the audit requirements of this part for that fiscal year.
- (5) Issue a management decision on audit findings within six months after receipt of the subrecipient's audit report and ensure that the subrecipient takes appropriate and timely corrective action.
- (6) Consider whether subrecipient audits necessitate adjustment of the pass-through entity's own records.
- (7) Require each subrecipient to permit the pass-through entity and auditors to have access to the records and financial statements as necessary for the pass-through entity to comply with this part.

Subsection B – Audits

210(a) General:

An auditee may be a recipient, a subrecipient, and a vendor. Federal awards expended as a recipient or a subrecipient would be subject to audit under this part. The payments received for goods or services provided as a vendor would not be considered Federal awards.

Title 15, Code of Federal Regulations, Part 24, Section 20 outlines responsibilities for entities receiving federal funds and states in part:

- (7) Cash management. Procedures for minimizing the time elapsing between the transfer of funds from the U.S. Treasury and disbursement by grantees and subgrantees must be followed whenever advance payment procedures are used. Grantees must establish reasonable procedures to ensure the receipt of reports on subgrantees' cash balances and cash disbursements in sufficient time to enable them to prepare complete and accurate cash transactions reports to the awarding agency. When advances are made by letter-of-credit or electronic transfer of funds methods, the grantee must make drawdowns as close as possible to the time of making disbursements. Grantees must monitor cash drawdowns by their subgrantees to assure that they conform substantially to the same standards of timing and amount as apply to advances to the grantees.

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A. Financial Requirements

.02 Award Payments

- d. Advances shall be limited to the minimum amounts necessary to meet immediate disbursement needs, but in no case should advances exceed the amount of cash required for a 30-day period. Advanced funds not disbursed in a timely manner and any applicable interest must be promptly returned to DOC.

J. Code of Conduct and Subaward, Contract, and Subcontract Provisions

.02 Applicability of Award Provisions to Subrecipients

- a. The recipient shall require all subrecipients, including lower tier subrecipients, under the award to comply with the provisions of the award, including applicable cost principles, administrative, and audit requirements.

09-05 The Employment Security Department did not comply with U.S. Department of Labor requirements for determining the accuracy of benefit payments.

Federal Awarding Agency: U.S. Department of Labor
Pass-Through Entity: None
CFDA Number and Title: 17.225 Unemployment Insurance
17.225 Unemployment Insurance – American Recovery and Reinvestment Act (ARRA)
Federal Award Number: UI-18054-09-55-A-53
Applicable Compliance Component: Special Tests – UI Benefit Payments
Questioned Cost Amount: None

Background

Federal regulations require the Department to operate a Benefits Accuracy Measurement program to assess the accuracy of unemployment insurance benefit payments and denied claims. The program estimates the number and amount of claims improperly paid or denied by projecting the results from investigations of small random samples to all claims.

The Department is required to draw a weekly sample of payments and denied claims, review the records, and contact claimants, employers and third parties to verify information related to the claim. If a claim was incorrectly paid, the investigator determines the amount of the error. For erroneously denied claims the investigator reports on the potential eligibility of the claimant; the cause of and the responsibility for the error; the point at which the error was detected; and actions taken by the agency and employer prior to the payment or denial decision that is in error.

The U.S. Department of Labor requires states to try to collect information needed for investigations using all of the following methods: in-person, telephone, FAX or mail. The only information Employment Security does not have to collect is from the claimant if he or she cannot be contacted or chooses not to respond.

Regarding claimants, the Department’s procedures manual directs investigators to attempt four telephone contacts at various times of the day and to follow up with at least two attempts to gather information by mail. If unsuccessful, the investigator may document the attempts and complete the investigation. The investigator is required to verify employer data, job search contacts and third-party information for each case. Federal regulations do not provide any option other than verifying the data directly and require Employment Security to use any and all methods necessary to confirm the data.

Federal guidelines require Employment Security to examine 480 paid claims and 450 denied claims each year. Employment Security received permission to reduce the number of claims examined to 360 for 2009 due to the increased workload coupled with reduced staffing. For 2008, the Department reported an 88.6 percent payment accuracy rate for paid claims based on the results of the Benefit Accuracy Measurement program.

Description of Condition

The Department is not using all methods specified by the federal guidance to collect data.

- For our audit we randomly selected 30 claims the Department had investigated and found:
 - In seven cases, the investigator did not verify wage data with prior employers. When contact was not made with the employer the case file would state: “Employer wages accepted as reported.”
 - In five cases, the investigator did not verify reported job searches with potential employers.
 - In one case, the Department did not contact a medical provider whose determination was essential to the claim in question.
 - Files for five of the cases did not document enough attempts to contact the claimant.

Cause of Condition

The Department stated it cannot force claimants, employers, and potential employers to provide information. The

Department is not, however, using all of the tools to collect information that are outlined in federal regulation. Specifically, the Department stopped performing in-person contacts in approximately 2003. It provided documentation from the U.S. Department of Labor it felt supported this decision.

Effect of Condition

The program accuracy rates are unreliable and possibly incorrect because the Department does not collect all data needed. Therefore, the Department may not be identifying potential issues with benefit claim approvals. This could lead to the Department paying invalid claims or denying valid claims.

Recommendation

We recommend the Department ensure all investigations performed as part of the Benefit Accuracy Measurement program include contacting the claimant, prior employers, job search contacts and third parties as required by the Department of Labor.

Department's Response

The finding and recommendation for the Benefit Accuracy Measurement (BAM) program has prompted ESD to closely examine the detailed procedures for auditing unemployment insurance claims. Thorough review of the BAM investigative procedures has helped ignite new ideas for process improvement.

The BAM unit randomly pulls 930 cases a year for both paid and denied cases. The sampling of this audit was 30 cases. 18 of the 30 cases were found to have incomplete information needed to verify facts. While the BAM investigators follow the current written procedures for investigating cases, we see an opportunity to be more aggressive in obtaining information and updating procedures to reflect changes for improvement.

The BAM team proposes several process improvement ideas to implement in 2010:

- Improve the record keeping of documented attempts to contact the claimant or employer.*
- Create and use a special "attention" stamp on all our envelopes of correspondence with verbiage to encourage the claimant and employer to respond.*
- Use certified mail in our letters of correspondence to both claimant and employer.*
- Set time specific appointments with claimants for the interview.*
- Increase the number of attempts to contact employers from two to four.*
- Make a more rigorous effort to verify all job search contacts, specifically the online applications.*
- Monitor investigator calls to observe content of their verbal communication.*

Additionally, the BAM team has started to conduct their own internal quality control process, where the team meets monthly to review peer cases and give feedback that outlines successes and areas for improvement. We have a new BAM supervisor with an adjudication background who will lead this effort and monitor the quality of cases more closely.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 20, Code of Federal Regulations, Part 602.21 states:
§ 602.21 Standard methods and procedures.

Each State shall:

- (a) Perform the requirements of this section in accordance with instructions issued by the Department, pursuant to § 602.30(a) of this part, to ensure standardization of methods and procedures in a manner consistent with this part;

- (b) Select representative samples for QC study of at least a minimum size specified by the Department to ensure statistical validity (for benefit payments, a minimum of 400 cases of weeks paid per State per year);
- (c) Complete prompt and in-depth case investigations to determine the degree of accuracy and timeliness in the administration of the State UI law and Federal programs with respect to benefit determinations, benefit payments, and revenue collections; and conduct other measurements and studies necessary or appropriate for carrying out the purposes of this part; and in conducting investigations each State shall:
 - (1) Inform claimants in writing that the information obtained from a QC investigation may affect their eligibility for benefits and inform employers in writing that the information obtained from a QC investigation of revenue may affect their tax liability,
 - (2) Use a questionnaire, prescribed by the Department, which is designed to obtain such data as the Department deems necessary for the operation of the QC program; require completion of the questionnaire by claimants in accordance with the eligibility and reporting authority under State law,
 - (3) Collect data identified by the Department as necessary for the operation of the QC program; however, the collection of demographic data will be limited to those data which relate to an individual's eligibility for UI benefits and necessary to conduct proportions tests to validate the selection of representative samples (the demographic data elements necessary to conduct proportions tests are claimants' date of birth, sex, and ethnic classification)

09-06 The Employment Security Department does not adequately review job search logs to ensure unemployment insurance claimants are eligible for benefits.

Federal Awarding Agency: U.S. Department of Labor
Pass-Through Entity: None
CFDA Number and Title: 17.225 Unemployment Insurance
17.225 Unemployment Insurance, American Recovery and Reinvestment Act (ARRA)
Federal Award Number: UI-18054-09-55-A-53
Applicable Compliance Component: Eligibility
Questioned Cost Amount: None

Background

Washington State employers fund unemployment insurance benefits through payroll taxes. The tax collections are kept in a trust fund administered by the U.S. Department of Labor through the U.S. Department of the Treasury. In fiscal year 2009, the Washington State Employment Security Department issued approximately \$560 million in federal unemployment benefit payments.

Federal law provides states flexibility in establishing requirements for job search activity by unemployment insurance claimants. Once established, however, states must abide by those requirements. Washington state law requires the Employment Security Department to have a job search monitoring program to ensure claimants receiving benefits are documenting at least three job search contacts or in-person job search activities each week. Department administrative rules outline job search requirements, including the frequency and types of activities that qualify. Claimants must document activities in order to remain eligible for benefits:

- For job search contacts, record the date contact was made; the employer's name, address and telephone number; the type of contact (in-person, telephone, etc.); the name of the person you contacted; and the type of work applied for.
- For in-person job search activities at the WorkSource office or local reemployment center, the date contact was made; and a description of the services received or the activities in which the claimant participated.

State law establishes penalties for claimants who do not comply with job search requirements, including a loss of benefits for those weeks during which the individual was not in compliance. Claimants found to have been out of compliance after benefits had been paid are liable for repayment of those benefits.

Description of Condition

We reviewed the Department's Job Search Log Review process, including secondary reviews of the initial determinations of job search log compliance. We found several instances of non-compliance. Department staff:

- Are approving Job Search Logs that do not meet the criteria for compliance. This is occurring at the WorkSource offices during claimant interviews. Additionally, during secondary reviews performed by the WorkSource Standards and Integration Division and the Unemployment Insurance Performance Audit unit, these logs are not being identified as non-compliant.
 - Thirteen of 45 job search logs we examined were missing required information including name of employer, position applied for and employer contact information.
- Are approving Internet job searches that contain only a date of application, an e-mail address, a job listing number and the type of position applied for. Management stated Internet job searches often are held to a different standard. State law does not differentiate between standard searches and those performed via the Internet.
- Are writing "HR" (for Human Resources) in the contact information spot on job search logs which have no contact entered. We noted this occurring at two of the five WorkSource offices where we did audit work. Employment and Career Development Division management stated it is not acceptable for Department staff to enter any information on a job search log on behalf of a claimant.

Cause of Condition

The Department is not adequately reviewing for job search contact compliance by claimants. It is relying on use of a standard of reasonableness that each employee is applying without any written guidance. This was confirmed with supervisors and management at WorkSource offices, the Employment and Career Development Division, the Unemployment Insurance Performance Audit Unit, and both of the TeleCenters.

The Department is not following established state law in regards to monitoring all required job search contact information. It is accepting Internet job search contacts with less than the seven required components.

The Department established a position of Job Search Review Manager that is responsible for providing training and guidance to Department staff who perform job search reviews. However, this position was vacant from May 2008 through January 2009, a period that saw large increases in the number of Unemployment Insurance claimants staff workload.

Effect of Condition

The Department is paying Unemployment Insurance benefits to claimants who do not meet eligibility requirements. This reduces the funding available for eligible claimants.

Recommendation

We recommend the Department ensure all employees performing reviews of job search contacts are aware of eligibility requirements. We further recommend the Department consistently apply these requirements to all job search contacts, regardless of the method used to perform the contact. The Department should monitor to ensure staff is consistently and accurately reviewing and verifying job search logs.

Department's Response

The Employment Security Department recognizes there has been a historical shift in methods used for how people apply for jobs today. Most jobs now require that the applicant apply online and often to a "blind ad posting". Employers determine the recruitment and application methods for available positions.

As a result, the department is revising regulations to address job search contacts, including contacts made in the on-line/internet world. Revisions related to job search contacts will be immediately incorporated into Job Search Review (JSR) program information, on-line resources, and training materials when approved. Staff are advised to ask additional clarifying questions with the claimant regarding their job search contacts to make sure all requirements for the contact are met.

The department makes every reasonable effort to ensure that job search contact requirements are consistently applied, regardless of the method of contact. The department is committed to fair and equitable treatment of all customers.

Staff performing JSR will be made aware of and have access to numerous resources that clearly define the program requirements. The department's Unemployment Insurance (UI) Division maintains a comprehensive reference website for staff that includes links to:

- § *The UI Resource Manual – Job Search Review section, has been provided to all offices*
- § *Applicable Laws and Regulations*
- § *Desk Aids*
- § *Weekly Policy Updates*
- § *WorkSource UI Liaison Information.*

Other resources available include local training and coaching provided by trained JSR staff. A two-and-a-half day formal JSR training is available and includes a comprehensive Training/Resource Manual for each trainee. A one day UI Reemployment Supervisors training that includes JSR requirements also is available.

Supervisory reviews of monthly JSR activity will be conducted in WorkSource offices. Technical assistance is provided by Employment and Career Development Division (ECDD) Reemployment Services Administration staff. If questions arise related to program requirements, UI Policy is consulted and the response shared with the appropriate staff.

The department will be conducting job search log quality and performance monitoring on a weekly and monthly basis. Logs will be requested from a minimum of six WorkSource offices each quarter by ECDD Reemployment Services Administration staff. A standard format will be used to evaluate the logs for legal requirements and quality. Offices may be monitored multiple times. Other monitoring efforts include onsite technical assistance, monthly sampling of job search logs from selected locations, and formal corrective action plans, if necessary. Offices are selected based on workload, staffing, and results of previous monitoring conducted by ECDD.

The department's WorkSource Standards and Integration Division (WSID) also independently schedules monitoring visits to WorkSource locations monthly and includes job search log reviews. ECDD coordinates with WSID to address and resolve findings/exceptions identified during an onsite review.

Also, weekly random samples of job search logs are submitted to the UI Performance Audit Unit for verification. The UI Performance Audit Unit and ECDD staffs meet monthly to discuss job search log quality, common issues and process improvements.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 20 Code of Federal Regulations, section 604.5 Application—availability for work

- (a) *General application.* A State may consider an individual to be available for work during the week of unemployment claimed under any of the following circumstances:
 - (1) The individual is available for any work for all or a portion of the week claimed, provided that any limitation placed by the individual on his or her availability does not constitute a withdrawal from the labor market.
 - (2) The individual limits his or her availability to work which is suitable for such individual as determined under the State UC law, provided the State law definition of suitable work does not permit the individual to limit his or her availability in such a way that the individual has withdrawn from the labor market. In determining whether the work is suitable, States may, among other factors, take into consideration the education and training of the individual, the commuting distance from the individual's home to the job, the previous work history of the individual (including salary and fringe benefits), and how long the individual has been unemployed.
 - (3) The individual is on temporary lay-off and is available to work only for the employer that has temporarily laid-off the individual.
- (b) *Jury service.* If an individual has previously demonstrated his or her availability for work following the most recent separation from employment and is appearing for duty before any court under a lawfully issued summons during the week of unemployment claimed, a State may consider the individual to be available for work. For such an individual, attendance at jury duty may be taken as evidence of continued availability for work. However, if the individual does not appear as required by the summons, the State must determine if the reason for non-attendance indicates that the individual is not able to work or is not available for work.
- (c) *Approved training.* A State must not deny UC to an individual for failure to be available for work during a week if, during such week, the individual is in training with the approval of the State agency. However, if the individual fails to attend or otherwise participate in such training, the State must determine if the reason for non-attendance or non-participation indicates that the individual is not able to work or is not available for work.

- (d) *Self-employment assistance.* A State must not deny UC to an individual for failure to be available for work during a week if, during such week, the individual is participating in a self-employment assistance program and meets all the eligibility requirements of such self-employment assistance program.
- (e) *Short-time compensation.* A State must not deny UC to an individual participating in a short-time compensation (also known as worksharing) program under State UC law for failure to be available for work during a week, but such individual will be required to be available for his or her normal workweek.
- (f) *Alien status.* To be considered available for work in the United States for a week, the alien must be legally authorized to work that week in the United States by the appropriate agency of the United States government. In determining whether an alien is legally authorized to work in the United States, the State must follow the requirements of section 1137(d) of the SSA (42 U.S.C. 1320b-7(d)), which relate to verification of and determination of an alien's status.
- (g) *Relation to ability to work requirement.* A State may consider an individual available for work if the State finds the individual able to work under §604.4(b) despite illness or injury.
- (h) *Work search.* The requirement that an individual be available for work does not require an active work search on the part of the individual. States may, however, require an individual to be actively seeking work to be considered available for work, or States may impose a separate requirement that the individual must actively seek work.

OMB Circular No. A-133, *Audits of States, Local Governments, and Non-Profit Organizations*,

Subpart C—Auditees

§ __.300 Auditee responsibilities.

The auditee shall:

- (a) Identify, in its accounts, all Federal awards received and expended and the Federal programs under which they were received. Federal program and award identification shall include, as applicable, the CFDA title and number, award number and year, name of the Federal agency, and name of the pass-through entity.
- (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.
- (c) Comply with laws, regulations, and the provisions of contracts or grant agreements related to each of its Federal programs.

RCW 50.20.010 states, in part:

- (1) An unemployed individual shall be eligible to receive waiting period credits or benefits with respect to any week in his or her eligibility period only if the commissioner finds that:
 - (i) With respect to claims that have an effective date before January 4, 2004, to be available for work an individual must be ready, able, and willing, immediately to accept any suitable work which may be offered to him or her and must be actively seeking work pursuant to customary trade practices and through other methods when so directed by the commissioner or the commissioner's agents.
 - (ii) With respect to claims that have an effective date on or after January 4, 2004, to be available for work an individual must be ready, able, and willing, immediately to accept any suitable work which may be offered to him or her and must be actively seeking work pursuant to customary trade practices and through other methods when so directed by the commissioner or the commissioner's agents. If a labor agreement or dispatch rules apply, customary trade practices must be in accordance with the applicable agreement or rules;

RCW 50.20.240 states, in part:

- (1) (a) To ensure that following the initial application for benefits, an individual is actively engaged in searching for work, the employment security department shall implement a job

search monitoring program. Effective January 4, 2004, the department shall contract with employment security agencies in other states to ensure that individuals residing in those states and receiving benefits under this title are actively engaged in searching for work in accordance with the requirements of this section. The department may use interactive voice technology and other electronic means to ensure that individuals are subject to comparable job search monitoring, regardless of whether they reside in Washington or elsewhere.

- (b) Except for those individuals with employer attachment or union referral, individuals who qualify for unemployment compensation under RCW 50.20.050 (1)(b)(iv) or (2)(b)(iv), as applicable, and individuals in commissioner-approved training, an individual who has received five or more weeks of benefits under this title, regardless of whether the individual resides in Washington or elsewhere, must provide evidence of seeking work, as directed by the commissioner or the commissioner's agents, for each week beyond five in which a claim is filed. With regard to claims with an effective date before January 4, 2004, the evidence must demonstrate contacts with at least three employers per week or documented in-person job search activity at the local reemployment center. With regard to claims with an effective date on or after January 4, 2004, the evidence must demonstrate contacts with at least three employers per week or documented in-person job search activities at the local reemployment center at least three times per week.
 - (c) In developing the requirements for the job search monitoring program, the commissioner or the commissioner's agents shall utilize an existing advisory committee having equal representation of employers and workers.
- (2) Effective January 4, 2004, an individual who fails to comply fully with the requirements for actively seeking work under RCW 50.20.010 shall lose all benefits for all weeks during which the individual was not in compliance, and the individual shall be liable for repayment of all such benefits under RCW 50.20.190.

Washington Administrative Code 192-180-010 states, in part:

Job search requirements – Directives

- (3) What are my weekly job search requirements?
 - (a) At a minimum, you must:
 - (i) Make job search contacts with at least three employers each week; or
 - (ii) Participate in three approved in-person job search activities at the WorkSource office or local employment center, or any combination of employer contacts or in-person job search activities for a total of three.
 - (b) Based on your individual circumstances, such as your occupation, experience, or labor market area, the department may issue you a directive requiring more than three employer contacts or job search activities each week.
 - (c) If you are a member of a referral union you must be registered with your union, eligible for and actively seeking dispatch, and comply with your union's dispatch or referral requirements (see WAC 192-210-120). Your benefits may be denied for any weeks in which you fail to meet these requirements and you may be directed to seek work outside of your union.
- (4) **What is a "job search contact"?** A job search contact is a contact with an employer to inquire about or apply for a job. You may use job search methods that are customary for your occupation and labor market area, including in-person, telephone, internet, or telefax contacts. The work applied for must be suitable (see RCW 50.20.100) unless you choose to look for work in a lower skill area. A contact does not count if it is made with an employer whom you know is not hiring, or if the department decides the contact is designed in whole or in part to avoid meeting the job search requirements.
- (5) **What is an "in-person job search activity"?** This is an activity provided through the WorkSource office or local employment center that will assist you in your reemployment efforts. It includes, but is not limited to, job search workshops, training classes, or other facilitated services provided by WorkSource staff and approved by the local WorkSource administrator. For claimants residing in Washington State, an in-person job search activity must be documented in the department's services, knowledge and information exchange system (SKIES) to qualify. For interstate claimants, the activity must be documented in the one-stop system in the state in which you reside.

Washington Administrative Code 192-180-015 states, in part:

Tracking job search activities –RCW 50.20.240

- (1) **Do I need to keep track of my job search activities?** You must keep a record or log of your job search contacts and the in-person job search activities you receive through the WorkSource office or local employment center unless you are:
 - (a) A member of a full referral union;
 - (b) Allowed benefits because you left work to protect yourself or a member of your immediate family from domestic violence or stalking as provided in RCW 50.20.050 (2)(b)(iv); or
 - (c) Exempt from job search requirements under WAC 192-180-010(1).

- (2) **What information do I need to keep in the log?** Your job search log must contain at least the following information:
 - (a) For job search contacts, record the date contact was made; the employer's name, address and telephone number; the type of contact (in-person, telephone, etc.); the name of the person you contacted; and the type of work you applied for;
 - (b) For in-person job search activities at the WorkSource office or local reemployment center, record the date contact was made; and a description of the services you received or the activities in which you participated.

Washington Administrative Code 192-180-030 - Penalties.

- (1) **Is there a penalty if I don't look for work or fail to report for the JSR interview as directed?**
Benefits will be denied if you fail to:
 - (a) Meet the minimum job search requirements;
 - (b) Provide information about your job search activities and, once you have been paid five weeks of benefits, provide a copy of your job search log upon request;
 - (c) Comply with any job search directive issued by the department; or
 - (d) Report to a scheduled job search review interview.~
- (2) **How long will my benefits be denied?** Benefits will be denied for the specific week or week(s) in which you fail to act as described in subsection (1).
- (3) **What is the penalty if I don't attend a JSR that has been scheduled to review all weeks claimed?**
If you fail to appear for a review of your job search logs for all weeks claimed, fail to produce your job search logs for those weeks, or your logs fail to establish that you have met the minimum job search requirements, such failure will be treated as nondisclosure under RCW 50.20.160(3) and your benefits may be denied for any weeks at issue.

09-07 The Employment Security Department’s internal controls are inadequate to ensure it complies with subrecipient monitoring requirements of the American Recovery and Reinvestment Act.

Federal Awarding Agency: U.S. Department of Labor
Pass-Through Entity: None
CFDA Number and Title: 17.258,.259,.260 Workforce Investment Act
17.258,.259,.260 Workforce Investment Act, American
Reinvestment and Recovery Act (ARRA)
Federal Award Number: Multiple
Applicable Compliance Component: Subrecipient Monitoring
Questioned Cost Amount: None

Background

The Employment Security Department administers the Workforce Investment Act program in the state. The program provides workforce preparation and employment services for dislocated workers and low-income youth and adults. In Washington, these services are provided through WorkSource, a partnership of state agencies, 12 local workforce development councils, community and technical colleges and non-profit service providers.

The Department spent more than \$3.8 million in federal American Recovery and Reinvestment Act (ARRA) funding on this program during fiscal year 2009.

The Act requires subrecipients to register in the Central Contractor Website database at www.ccr.gov before they bid on a contract involving ARRA money. This is to help ensure they all report the same type of data, such as bank and account records, in an effort to provide the public the public with consistent, useful information. The federal government communicated this requirement through an Addendum to the Act that states: "*Grantees and their subrecipients (first tier) must have a Dun and Bradstreet Numbering System (DUNS) number (www.dnb.com) and must maintain active and current profiles in the Central Contractor Registration (CCR). (www.ccr.gov).*"

Registration also is designed to assist subrecipients in reporting accurate information; in obtaining payment certification; and with federal tax collection.

On June 10, 2009, this requirement was further outlined in U.S Department of Labor Training and Employment Guidance Letter No. 29-08. The training letter stated, "*The DUNS/CCR requirement applies to all types of entities including direct recipients applying for Federal grants, cooperative agreements, or loans under the Recovery Act programs or activities and sub-recipients receiving funds under such awards. Recipients and sub-recipients must also maintain current registrations in the CCR at all times during which they have active Federal awards funded with Recovery Act funds.*"

Description of Condition

The Department did not verify that subrecipients ARRA funds were registered in the database prior to releasing ARRA funds.

The Department also had performed subrecipient monitoring at two locations; however, it had not determined during the review whether or not the subrecipient had maintained current information in the database.

Cause of Condition

The Department was informed of the requirement to inform subrecipients of ARRA funds of the need to register in the database, but had not confirmed registration prior to releasing funds. Management indicated it had not determined who was responsible for enforcement of the requirement.

Effect of Condition and Questioned Costs

The Department paid subrecipients before they were registered. It cannot ensure vendors were eligible to participate in federal programs. Payments to an ineligible party are unallowable and are subject to recovery by the grantor.

Subsequent to the year end, the Department verified that all 12 vendors awarded funding in state fiscal year 2009 were registered on the database; therefore we are not questioning these costs.

Recommendation

We recommend the Department:

- Ensure grant contracts with subrecipients are current and in compliance with ARRA requirements by federal regulation.
- Identify a point of responsibility for ensuring compliance with this requirement, and monitor for compliance.

Department's Response

The American Recovery and Reinvestment Act (ARRA) recovery funds identified in this finding were passed through to Workforce Development Councils (WDC) in accordance with Workforce Investment Act (WIA) formula calculations. All twelve of the WDCs have had longstanding contractual relationships with the Employment Security Department.

The department concurs that the Central Contractor Registration (CCR) database was not verified prior to the release of WIA ARRA funds. As noted by the auditor we have verified that all twelve of our WDC subrecipients are properly registered with the CCR and eligible to receive ARRA funds.

For future ARRA grants the department will ensure that this registration is included in the WDC grant agreements authorized by the WorkSource Standards and Integration Division. This requirement will also be included in the WDC annual monitoring conducted by the department. The Fiscal Office will verify this registration is current prior to releasing funds to the WDCs. The original grant agreements, including CCR registration information, will be maintained in the department's contracts office.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 300, states in part:

The auditee shall:

- (c) Comply with laws, regulations, and the provisions of contracts or grant agreements related to each of its Federal programs.

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Compliance Supplement Addendum #1, states in part:

A pass-through entity is responsible for:

Central Contractor Registration – Identifying to first-tier subrecipients the requirement to register in the Central Contractor Registration, including obtaining a Dun and Bradstreet Data Universal Numbering System (DUNS) number, and maintain the currency of that information (Section 1512(h), ARRA, and 2 CFR 176.50(c)).

Memorandum for the Heads of Departments and Agencies, Initial Implementing Guidance for the American Recovery and Reinvestment Act of 2009, states in part:

(4) Timeliness of Awards

Agencies need to assess existing processes for awarding formula allocations and announcing, evaluating and awarding discretionary grant opportunities to comport with the objective to make awards timely.

To enable timeliness of awards, agencies should engage in aggressive outreach to potential applicants to begin application planning activities, including the process for Central Contractor Registration (CCR) and obtaining a Dun and Bradstreet Universal Numbering System (DUNS) number. Outreach can also include efforts to update and validate existing CCR and DUNS registration data.

U.S Department of Labor Training and Employment Guidance Letter No. 29-08

Purpose: To inform the workforce system of the mandatory requirements for sub-recipients, i.e., any first-tier subcontract or sub-award funded in whole or in part under the American Recovery and Reinvestment ACT OF 2009 (Recover Act), to obtain a DUNS number www.dnb.com. Any such sub-recipient must also establish and maintain active and current profiles in the CCR at www.ccr.gov.

09-08 The Department of Transportation does not have internal controls to ensure that the American Recovery and Reinvestment Act Subrecipient Monitoring compliance requirements are identified and adhered to.

Federal Awarding Agency: U.S Department of Transportation
Pass-Through Entity: None
CFDA Number and Title: 20.205 Highway Planning and Construction
20.205 Highway Planning and Construction, American
Reinvestment and Recovery Act
Federal Award Number:
Applicable Compliance Component: Subrecipient Monitoring
Questioned Cost Amount: None

Background

The U.S Department of Transportation provides Highway Planning and Construction money to assist states in planning and developing a transportation system to accommodate interstate commerce and travel; to repair federal highways following disasters; to foster safe highway design; and to replace or rehabilitate bridges.

The State Department of Transportation spent nearly \$8 million in federal American Recovery and Reinvestment Act (ARRA) funding related to this program during fiscal year 2009. Of this, approximately \$6 million was spent through contracts with subrecipients.

The Act requires subrecipients of ARRA funds to register in the Central Contractor Registration (CCR) database at www.ccr.gov before they bid on a contract involving ARRA money. This is to help ensure they all report the same type of data, such as bank and account records, in an effort to provide the public with consistent, useful information. This requirement was communicated through an addendum to the Act that states: "*Grantees and their subrecipients must have a Dun and Bradstreet Numbering System (DUNS) number (www.dnb.com) and must maintain active and current profiles in the Central Contractor Registration (CCR). (www.ccr.gov).*"

Registration also is designed to assist subrecipients in reporting accurate information; in obtaining payment certification; and with federal tax collection.

Description of Condition

The Department did not inform subrecipients of ARRA funds they were required to create and maintain a current profile in the CCR.

The Department also did not verify that subrecipients were registered in the CCR database prior to releasing ARRA funds.

Cause of Condition

Department staff members responsible for ensuring compliance with federal regulations were not aware of the CCR registration requirement. Therefore the Department did not note this requirement in contracts with subrecipients or take other steps to inform them.

Effect of Condition

The Department paid subrecipients before verifying they were registered, and did not have controls to ensure compliance with this federal requirement. When we reviewed the CCR, we found the subrecipients were registered, and therefore are not questioning costs.

Recommendation

We recommend the Department:

- Ensure contracts with subrecipients are current and in compliance with ARRA requirements.

- Identify who is responsible for ensuring compliance with this requirement and monitor for compliance.
- Ensure all future subrecipients are aware of and comply with the registration requirement prior to awarding funds.

Department’s Response

Thank you for the finding on registering subrecipients who receive funds under the American Recovery and Reinvestment Act (ARRA).

As soon as the Department became aware of this requirement for subrecipient registration we modified our procedures to ensure compliance. We are now notifying subrecipients of the registration requirement and monitoring for their compliance with this requirement.

The Department goes to great lengths to identify and comply with requirements that come with ARRA funds, reviewing federal guidance on a regular basis and continually updating our procedures to ensure compliance. The registration requirement was added to the OMB Circular A-133 Compliance Supplement through Addendum #1 dated June 30, 2009, the last day of the fiscal year. While this requirement was introduced in another OMB document in April 2009, the Department’s Federal Highway Administration (FHWA) contact was not aware of this requirement. We will continue to stay apprised of federal requirements of ARRA funds and work hard to ensure compliance.

Auditor’s Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department’s corrective action during our next audit.

Applicable Laws and Regulations

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 300, states in part:

The auditee shall:

- (c) Comply with laws, regulations, and the provisions of contracts or grant agreements related to each of its Federal programs.

OMB Circular A-133 Compliance Supplement Addendum #1, states in part:

A pass-through entity is responsible for:

Central Contractor Registration – Identifying to first-tier subrecipients the requirement to register in the Central Contractor Registration, including obtaining a Dun and Bradstreet Data Universal Numbering System (DUNS) number, and maintain the currency of that information (Section 1512(h), ARRA, and 2 CFR 176.50(c)).

Memorandum for the Heads of Agencies and Agencies, Initial Implementing Guidance for the American Recovery and Reinvestment Act of 2009, states in part:

(4) Timeliness of Awards

Agencies need to assess existing processes for awarding formula allocations and announcing, evaluating and awarding discretionary grant opportunities to comport with the objective to make awards timely.

To enable timeliness of awards, agencies should engage in aggressive outreach to potential applicants to begin application planning activities, including the process for Central Contractor Registration (CCR) and obtaining a Dun and Bradstreet Universal Numbering System (DUNS) number. Outreach can also include efforts to update and validate existing CCR and DUNS registration data.

09-09 The Department of Transportation did not support over \$740,000 in payroll costs in accordance with federal regulations for the Formula Grants for Other Than Urbanized Areas.

Federal Awarding Agency: U.S. Department of Transportation, Federal Transit Administration
Pass-Through Entity: None
CFDA Number and Title: 20.509 Formula Grants for Other Than Urbanized Areas
Federal Award Number: WA-18-X023; WA-18-X024; WA-18-X025; WA-18-X039; WA-85-X001
Applicable Compliance Component: Allowable Costs/Cost Principles
Questioned Cost Amount: \$740,889.08

Background

The Public Transportation Division of the Washington State Department of Transportation administers the federal Formula Grants for Other Than Urbanized Areas grant that helps pay for public transportation serving rural areas. The Department distributes this money to public and private entities that provide this service and retains a small portion, between 10 and 15 percent, to pay its administrative costs. The Department spent \$10,114,016 in this grant money in fiscal year 2009.

Grant money may be used to pay only for costs that are allowable and related to the grant's purpose. Federal regulations specify the documentation that must be kept to support employee compensation charged to federal grants. If an employee works solely on the grant program, and all related payroll costs are charged to that grant, minimal documentation is required: the employee must certify, semi-annually, in writing, that he or she worked solely on that program. Requirements state that for employees who work on multiple programs or whose positions are funded by multiple sources, payroll costs must be supported by personnel activity reports or equivalent documentation, such as timesheets. These reports must:

- Reflect how much time the employee worked on each program.
- Account for the total activity for which the employee is compensated.
- Be prepared at least monthly and coincide with one or more pay periods.
- Be signed by the employee.

Payroll estimates are allowable if adjustments to actual costs are made at least quarterly. Closely related programs with differing funding sources may be deemed a single cost objective, and therefore are subject only to the semi-annual certifications. This designation must be applied for and approved by the federal grantor. The Department has not applied for approval for this designation for the Formula Grants for Other Than Urbanized Areas program. The federal requirements are detailed in the federal Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Tribal Governments*.

Description of Condition

The Public Transportation Division administers a number of closely related federal and state programs, and the work performed by administrative and program personnel support multiple programs.

The Division charged a portion of the payroll costs for 14 employees to the grant based on budgeted percentages. The Division did not have documentation to support the charges and they were not reconciled to actual time employees worked on various programs. We identified two employees who work solely on the program that did not complete the semi-annual certifications.

These payroll costs totaled \$740,889.08.

Cause of Condition

The Public Transportation Division management responsible for allocating payroll costs stated it allocated costs to the grant in accordance with guidance received from the grantor. It was unaware that guidance does not meet the requirements of Circular A-87 for allocating costs to federal programs.

Effect of Condition and Questioned Costs

Without adequate time and effort documentation federal grantors cannot be assured that salaries and wages charged to their programs are accurate and valid. This could jeopardize future federal funding to the Department.

We identified \$740,889.08 in direct payroll charges to the Formula Grants for Other Than Urbanized Areas grant that were not supported in accordance with federal requirements. We are questioning those costs as unallowable charges for salaries and benefits. The federal grantor could disallow these charges and require the Department to pay back the money.

Recommendations

We recommend the Department of Transportation review Circular A-87 to gain an understanding of the federal requirements for documentation of direct payroll charges to grants. Policies and procedures should be established and followed to ensure payroll charges are adequately supported. Additionally, the Department should consult with its federal grantor to determine the most appropriate method for charging these costs to federal grants in accordance with the requirements of Circular A-133.

The Department should consult with its grantor to determine what, if any, of the questioned costs should be repaid.

Department's Response

The Department appreciates the finding regarding payroll costs charged to the Formula Grants for Other Than Urbanized Areas, and will make the necessary changes to follow the audit recommendations.

The Department's current method for allocating direct payroll expenditures was approved by the grantor, the Federal Transit Administration (FTA), so the Department believed its allocation method was in compliance with Federal Regulations. As mentioned in the finding, the Department's Public Transportation Division administers a number of closely related grant programs, and the work performed by some staff support multiple programs. The Department is considered an innovative leader by FTA for its grant administration methods. However, we appreciate the State Auditor's recommendations. The Department has begun to formalize its allocation of direct payroll costs, to meet the Federal requirements for a "substitute system," as addressed in the Federal regulations (OMB Circular A-87). We will work with FTA to receive grantor approval of that system. In addition, we will update policies and procedures to reflect the approved "substitute system".

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

The Federal criteria for the determination of costs for states is U.S. Office of Management and Budget's Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*.

Attachment B, Section 8(h) of the Circular states in part:

Support of salaries and wages. These standards regarding time distribution are in addition to the standards for payroll documentation.

- (1) Charges to Federal awards for salaries and wages, whether treated as direct or indirect costs, will be based on payrolls documented in accordance with generally accepted practice of the governmental unit and approved by a reasonable official(s) of the governmental unit.
- (2) No further documentation is required for the salaries and wages of employees who work in a single indirect cost activity.
- (3) Where employees are expected to work solely on a single Federal award or cost objective, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that program for the period covered by the certification. These

certifications will be prepared at least semi annually and will be signed by the employee or supervisory official having first hand knowledge of the work performed by the employee.

- (4) Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation which meets the standards in subsection 8.h.(5) of this appendix unless a statistical sampling system (see subsection 8.h.(6) of this appendix) or other substitute system has been approved by the cognizant Federal agency. Such documentary support will be required where employees work on:
 - (a) More than one Federal award
 - (b) A Federal award and a non Federal award
 - (c) An indirect cost activity and a direct cost activity
 - (d) Two or more indirect activities which are allocated using different allocation bases, or
 - (e) An unallowable activity and a direct or indirect cost activity
- (5) Personnel activity reports or equivalent documentation must meet the following standards:
 - (a) They must reflect an after the fact distribution of the actual activity of each employee.
 - (b) They must account for the total activity for which each employee is compensated
 - (c) They must be prepared at least monthly and must coincide with one or more pay periods, and
 - (d) They must be signed by the employee
 - (e) Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to Federal awards but may be used for interim accounting purposes, provided that:
 - (i) The governmental unit's system for establishing the estimates produces reasonable approximations of the activity actually performed;
 - (ii) At least quarterly, comparisons of actual costs to budgeted distributions based on the monthly activity reports are made. Costs charged to Federal awards to reflect adjustments made as a result of the activity actually performed may be recorded annually if the quarterly comparisons show the differences between budgeted and actual costs are less than ten percent; and
 - (iii) The budget estimates or other distribution percentages are revised at least quarterly, if necessary, to reflect changed circumstances.
- (6) Substitute systems for allocating salaries and wages to Federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort.
 - (a) Substitute systems which use sampling methods (primarily for Temporary Assistance to Needy Families (TANF), Medicaid, and other public assistance programs) must meet acceptable statistical sampling standards including:
 - (i) The sampling universe must include all of the employees whose salaries and wages are to be allocated based on sample results except as provided in subsection 8.h.(6)(c) of this appendix;
 - (ii) The entire time period involved must be covered by the sample; and
 - (iii) The results must be statistically valid and applied to the period being sampled.
 - (b) Allocating charges for the sampled employees' supervisors, clerical and support staffs, based on the results of the sampled employees, will be acceptable.
 - (c) Less than full compliance with the statistical sampling standards noted in subsection 8.h.(6)(a) of this appendix may be accepted by the cognizant agency if it concludes that the amounts to be allocated to Federal awards will be minimal, or if it concludes that the system proposed by the governmental unit will result in lower costs to Federal awards than a system which complies with the standards.
- (7) Salaries and wages of employees used in meeting cost sharing or matching requirements of Federal awards must be supported in the same manner as those claimed as allowable costs under Federal awards.

Attachment B, Section 8(d) of the Circular states in part:

Fringe benefits.

- (2) The cost of fringe benefits in the form of regular compensation paid to employees during periods of authorized absences from the job, such as for annual leave, sick leave, holidays, court leave, military leave, and other similar benefits, are allowable if:the costs are equitably allocated to all related activities, including Federal awards;.....

09-10 The Department of Commerce, Energy Division, does not have controls to ensure it complies with reporting requirements for the State Energy Program.

Federal Awarding Agency: U.S. Department of Energy
Pass-Through Entity: None
CFDA Number and Title: 81.041 State Energy Program
81.041 State Energy Program – American Recovery and Reinvestment Act (ARRA)
Federal Award Number: DE-FJ26-05R021613; DE-EE0000139
Applicable Compliance Component: Reporting
Questioned Cost Amount: None

Background

The federal State Energy Program provides financial and technical assistance to states on energy priorities, emerging renewable energy sources and energy efficiency technologies. The Energy Division of the Department of Commerce administers the program in Washington state.

Federal requirements state financial and program status reports must be submitted to the federal grantor quarterly and within 30 days after the end of each calendar quarter.

The U.S. Department of Energy awarded \$785,000 in State Energy Program grant money in fiscal year 2009. While this amount is relatively small for a state award, Commerce is slated to receive approximately \$60 million in State Energy Program funding through the American Reinvestment and Recovery Act (ARRA). We reviewed the Department's compliance with federal requirements to determine if it has adequate systems in place prior to the receipt of the ARRA money.

Description of Condition

The Department did not submit financial and program status reports to the federal grantor within 30 days after the end of each quarter of the fiscal year.

- The report for the quarter ending September 2008 was not submitted until November 18, 2008.
- The report for the quarter ending December 2008 was not submitted until September 17, 2009.
- The reports for the quarters ending March and June 2009 were not submitted until September 24, 2009.

These dates were verified by the federal grantor.

Cause of Condition

Department management did not ensure that staff responsible for administering the State Energy Program submitted financial and program status reports on time.

Effect of Condition and Questioned Costs

Grantors rely on timely, accurate reports to monitor the progress of programs and the use of federal dollars. By not submitting the reports by the required date, the Department prevented the grantor from adequately monitoring the State Energy program. In addition, grant conditions allow the grantor to penalize the Department for noncompliance by withholding payments, suspending or terminating the award, and withholding future awards, as well as taking action to preclude future awards.

Recommendation

We recommend the Department institute a system of monitoring to ensure all staff responsible for submitting the quarterly financial and program status reports to the federal grantor do so by the deadline.

Department's Response

We concur with the finding. As noted in the finding, the required status reports were filed before the audit was completed. Program staff has developed a tickler system to ensure that status reports are filed timely in the future.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 10, Code of Federal Regulations, Part 420 states:

420.5 Reports

- (a) Each state receiving financial assistance under this part shall submit to the cognizant Regional Office Director a quarterly program performance report and a quarterly financial status report (FSR).
- (c) The reports shall be submitted within 30 days following the end of each calendar year quarter.

Catalog of Federal Domestic Assistance 81.041, Reports states in part:

...Quarterly progress and financial status reports are required along with a final report at the end of the project.

State Energy Program grant Special Terms and Conditions, Part 5a:

Failure to comply with these reporting requirements is considered a material noncompliance with the terms of the award. Noncompliance may result in withholding of future payments, suspension or termination of the current award, and withholding of future awards. A willful failure to perform, a history of failure to perform, or unsatisfactory performance of this and/or other financial assistance awards, may also result in a debarment action to preclude future awards by Federal agencies.

09-11 The Department of Social and Health Services does not ensure that Temporary Assistance to Needy Families payments are reduced for clients who do not participate in WorkFirst activities as required by state law.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: 93.558 Temporary Assistance for Needy Families
Federal Award Number: G0902-WATANF
Applicable Compliance Component: Special Test and Provision N3- Penalty for Refusal to Work
Questioned Cost Amount: \$506.00

Background

The Department of Social and Health Services Economic Services Administration administers the Temporary Assistance to Needy Families (TANF) program for the state to provide time-limited assistance to needy families with children so that the children can be cared for in their own homes or in the homes of relatives. The program served approximately 56,000 households each month and spent more than \$484 million in fiscal year 2009.

Federal law requires the Department to submit a state plan, which outlines the rules, policies and procedures the Department will follow in administering the program. The state plan in place during the audit period requires TANF clients, beginning at age 16, to participate in WorkFirst, a program designed to help low-income families prepare for and find work. In Washington, WorkFirst participation by clients between 16 and 19 is defined as being enrolled in and attending school or actively pursuing a high school diploma equivalent. Clients who are 18 or 19 must participate in job search activities if they have a high school diploma or equivalent. The families of approximately 10,000 clients in Washington between 16 and 19 receive TANF benefits each month. Progress and participation in WorkFirst activities is recorded in the electronic Jobs Automated System.

Department case workers are required to ensure WorkFirst participation by clients. An Individual Responsibility Plan is developed with each child and his or her parent or guardian. Non-compliance with the plan would result in a reduction of benefits up to 40 percent.

In our audit of fiscal year 2008, we reported the Department does not ensure Temporary Assistance to Needy Families payments are reduced for dependent teen clients, beginning at age 16, who do not participate in WorkFirst activities as required by state and federal law.

Description of Condition

In response to the 2008 audit finding, the Department said state law governing teen education requirements apply to teens who are parents, not to teens in general. The Department stated it was going to amend the TANF State Plan to eliminate the requirement to sanction dependent 16 and 17 year olds who are not in school. In addition, the Department stated it would revise the state rule and WorkFirst Handbook to eliminate the requirement that these 16 and 17 year olds attend school.

During our current audit, we found the Department did not take action in time for the changes to be in place before the end of the fiscal year. The Department's WorkFirst Handbook was not updated and effective until August 14, 2009, and the revision of the state rule removing the language was adopted and filed on July 14, 2009. The rule became permanent 31 days after being filed.

Cause of Condition

The Department didn't complete the rule change promptly due to the hearing and administrative procedures. The revised WAC was initially drafted and filed on May 1, 2009 and it was finally adopted on July 14, 2009.

Effect of Condition and Questioned Costs

During the fiscal year, the Department did not comply with federal requirements regarding teen beneficiaries of TANF. During our fiscal year 2008 audit, we identified likely questioned costs related to this issue approaching \$1 million. During this audit we identified \$506 in questioned costs related to three households not in compliance with

the requirement. The Department made no changes to its process and the issues were resolved through rule change during fiscal year 2010. After considering the time and effort required to test individual client WorkFirst participation, we did not expand individual testing and therefore we have not identified additional questioned costs.

Recommendation

We recommend the Department ensure TANF State Plan and rules are current and reflect the Department's intent and obligations. Actual practices should be consistent with State Plan and Department rules.

Department's Response

The Department partially concurs with the finding.

As stated, the final rule was adopted on July 14, 2009. The Administrative Procedures Act provides guidance regarding the timing of rule filings, hearings, etc. to allow sufficient time for public review and comment of draft rules. The revised WAC was initially drafted and filed on May 1, 2009, and adopted on July 14, 2009. The rule became permanent 31 days after being filed. The WorkFirst Handbook was updated and effective August 14, 2009. The revisions eliminate the requirement to sanction dependent 16 and 17 year olds who were not in school. In addition, the Department revised the state rule and WorkFirst Handbook to eliminate the requirement that these 16 and 17 year olds attend school.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 300, states in part:

The auditee shall:

- (c) Comply with laws, regulations, and the provisions of contracts or grant agreements related to each of its Federal programs.

Washington Administrative Code 388-310-0200 in effect during the audit period states:

- “(a) You are required to participate in WorkFirst activities, and become what is called a "mandatory participant," if you:
 - (i) Receive TANF or SFA cash assistance; and
 - (ii) Are a custodial parent or age sixteen or older; and
 - (iii) Are not exempt.”

Washington Administrative Code 388-310-0900 states:

- “(c) You will be required to be in high school or a GED certification program if you are a mandatory participant, sixteen or seventeen years old and you do not have a high school diploma or GED certificate.”

Washington Administrative Code 388-310-1600 states:

- “When you are a mandatory WorkFirst participant, you must follow WorkFirst requirements to qualify for your full grant. If you or someone else on your grant doesn't comply and you can't prove that you had a good reason, you do not qualify for your full grant. This is called being in WorkFirst sanction status.
 - (a) When someone in your household is in sanction status, we impose penalties. The penalties last until you or the household member meet WorkFirst requirements.
 - (b) Your grant is reduced by the person(s) share or forty percent, whichever is more.”

09-12 The Department of Early Learning and the Department of Social and Health Services do not have adequate internal controls over direct payments to child care providers.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: 93.575 Child Care and Development Block Grant
93.596 Child Care Mandatory and Matching Funds of the Child
Care and Development Fund
93.713 Child Care and Development Block Grant, American
Reinvestment and Recovery Act (ARRA)
Federal Award Number: G-0901 WACCDF
Applicable Compliance Component: Activities Allowed or Unallowed
Questioned Cost Amount: None

Background

The Washington Department of Early Learning (DEL) administers the federal Child Care and Development program to assist eligible working families in paying for child care. In fiscal year 2009, the Department paid approximately \$212 million to child care centers and providers through the Working Connections Child Care Program.

The Department of Social and Health Services (DSHS) performs many functions related to the grant under an agreement with DEL, including processing payments to child care providers.

Our audits of fiscal years 2005-2008 reported the Departments did not adequately monitor direct payments made to child care providers. Payments are made through the Social Services Payment System (SSPS) maintained by DSHS. Monitoring is critical to ensure payments are allowable.

Description of Condition

In response to the 2008 audit finding, the Departments began reconciling child care payments to child care provider attendance records to determine if the payments were supported by documentation. In addition, the Departments trained providers on proper billing procedures. The Departments documented their own responsibilities in a Service Level Agreement.

Each month, DSHS randomly selects payment files for licensed child care centers and licensed family homes. DEL sends a written request to the providers for attendance records and provides them to DSHS to reconcile with the SSPS payment files. If a provider fails to provide attendance records or a discrepancy is found, DSHS follows DEL policy and records it as an overpayment.

We found DSHS was requesting attendance records and reconciling them to child care payments. However, the Department had limited the reconciliations to 54 children each month; three from three centers from each of its six regions. When overpayments were identified for a child at one center, the Department did not expand its review to determine if that provider had claimed additional unsupported payments. Additional testing is difficult as the provider is permitted to edit the attendance sheet and block out information on other possible overpayments.

We reviewed documentation that showed the Department reviewed \$248,945 in payments for child care for fiscal year 2009, less than .38 percent of the total payments. Attendance records related to \$32,378 of these payments lacked the required signatures of parents with children whose care was being paid for. Additionally, the Department was unable to obtain attendance records it requested related to \$26,733 of the payments. The Department found overpayments in 37 percent of the payments it reviewed, which should have resulted in an expanded review. The number of attendance records reviewed by the Department was inadequate to address the risk of inappropriate claims.

The inadequate monitoring of direct payments, specifically the lack of reconciliation between child attendance records and payment requests submitted by providers, has not been resolved.

Cause of Condition

Although the Departments reached an agreement regarding their roles and responsibilities as they relate to child care payment reconciliations, they did not define what would constitute adequate reconciliation of direct payments, resulting in minimal efforts to identify and collect overpayments.

Effect of Condition

The lack of controls over payments to providers results in a high risk that overpayments to providers will be made and not identified or recovered. The Departments are aware of overpayments and that providers are claiming more than authorized amounts.

While we recognize the improvements both Departments have made over the monitoring of child care payments, the inadequacy of the system for reconciling payments to source documentation is a significant control weakness that leaves the program vulnerable to abuse. We performed a detailed review of a small sample of payments and attendance records during our fiscal year 2006 audit and found more than \$55,000 in overpayments. Since the Departments did not have a reconciliation process at that time, and because of the time and effort involved in a detailed review of child care attendance records, we determined that re-performing this review would not be an effective use of our resources.

Recommendation

We recommend the Departments establish and follow detailed monitoring procedures for provider payments to include adequate reconciliation of provider attendance records to payments made to ensure expenditures are allowable. When exceptions are found, the Departments should expand their review to determine if additional costs could be recovered.

Departments' Response

The Departments of Early Learning and Social and Health Services have numerous activities in place to insure there are adequate internal controls over payments to child care providers and will implement additional measures.

- 1. DEL contracts with DSHS to compare a sample of subsidy billing with attendance records. If DSHS Finds providers that appear to not understand proper billing methods, they will contact DEL. DEL will provide technical assistance, scholarship funds, and encourage providers to attend subsidy training classes through the State Training and Registry System or through training required by the collective bargaining agreement for the family child care home provider.*
- 2. DEL will require that DSHS expand the scope of their subsidy billing reconciliation review when they find a provider that has billed incorrectly. DSHS will examine additional records of the providers who have billed incorrectly, and write overpayments for incorrect billing. They will report their findings to the DEL monthly.*
- 3. DEL is releasing a new Subsidy Billing Booklet in the next couple of months. This guide book will assist providers in proper billing methods. In addition to providing better instructions, DEL is streamlining some of the calculations, such as absent days, to make it easier for providers to bill properly. DEL expects to see improvements in billing once providers have this new booklet.*

Auditor's Concluding Remarks

We thank the Departments for its cooperation and assistance throughout the audit. We will review the status of the Departments' corrective action during our next audit.

Applicable Laws and Regulations

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 300, states in part:

The auditee shall:

- (b) Maintain internal control over Federal programs that provides reasonable assurance

that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.

OMB Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*.

Attachment A, Section C, Basic Guidelines, states in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria: ...
 - j. Be adequately documented.

Washington Administrative Code 170-295-7030 states in part:

- (3) Attendance records and invoices for state paid children must be kept on the premises for at least five years after the child leaves your care.

Washington Administrative Code 170-296-0520 states in part:

- (3) Daily attendance records, listing the dates and hours of attendance of each child must be kept up-to-date and maintained in the licensed space of the family home child care for five years.
- (4) When a child is no longer enrolled, the date of the child's withdrawal must be recorded in the child's file. You must maintain the child's file for at least five years from the child's last date of attendance. After five years the file may be destroyed or returned to the parent. The child's file must be made available for review by the child's parents and us during this period.

09-13 The Department of Social and Health Services, Children's Administration, does not ensure the eligibility of foster care payment recipients prior to paying them.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: 93.658 Foster Care
93.658 Foster Care, American Reinvestment and Recovery Act
Federal Award Number: N/A
Applicable Compliance Component: Eligibility
Questioned Cost Amount: \$48,602.20

Background

Title IV-E Foster Care provides money to states to assist with paying for foster care for certain eligible children; with administrative costs to manage the program; and with training for the state agency staff, foster parents and certain private agency staff. Eligibility is based on a need for the child to be removed from their current household, and to be placed in the care of a fully licensed foster care provider.

The Department of Social and Health Services paid \$51.2 million in federal Title IV-E funds for foster care for approximately 6,200 children during fiscal year 2009. The Department uses an electronic case management system to track and monitor these payments. In February 2009, the Department began using a new case management system, which required all data from the old system be transferred to it.

Description of Condition

We reviewed case files for 30 children in foster care, representing \$61,028 in payments using Title IV-E money, to determine if they were eligible and if payments were properly supported. Our selection of the files was based on the type of payment made (basic foster care, special supervision, transportation), the amount of payment, and the age of the child.

We found:

One instance in which the provider had only a 'provisional' license, and therefore did not qualify for federal assistance. Providers must be fully licensed to be eligible. Payments associated with this case file were \$9,471.90.

Three case files in which payments were made when the recipient was determined not to be eligible, because they were over the age of 18. We noted two of these incidents appear to be related to errors made during the case management system conversion. The third appears due to human error. Payments associated with these three case files totaled \$24,483.40.

Based on the errors that occurred due to the case management system conversion, we requested the Department analyze all converted cases to determine if other errors occurred. The Department performed this analysis, and identified 27 additional inappropriate payments. Payments associated with these cases totaled \$14,646.90.

Cause of Condition

Department management did not sufficiently monitor to ensure payments were made only to eligible providers. Department staff also did not follow established procedures for stopping payments when the child became ineligible, which allowed payments to continue. The Department did not perform adequate testing when converting to a new case management system that all data had migrated accurately.

Effect of Condition and Questioned Costs

The Department made payments to ineligible foster parents. We are questioning \$33,955.30 in payments for the three cases identified above, plus an additional \$14,646.90 identified by the Department as inappropriate, for a total of \$48,602.20 in questioned costs. The weaknesses identified increase the risk of additional inappropriate payments being made without detection.

Recommendation

We recommend the Department:

- Follow established internal controls for monitoring case files to ensure recipients are eligible and that payments are fully supported.
- Fully test the files migrated to the new case management system to ensure data accuracy.
- Communicate with the federal grantor to determine whether questioned costs need to be repaid.

Department's Response

The Department concurs with this finding.

We have begun a process to identify all cases that have been paid using a source of funds (SOF) not consistent with the eligibility of the client. These cases will be corrected in FamLink which will automatically process a correction of payment to adjust the funding according to the correct eligibility information. FamLink uses eligibility information on the case to determine the correct SOF and does not rely on a manual determination from the worker.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 4.93.658 CFDA 93.658 Foster Care – Title IV-E, states in part:

E. Eligibility

1. Eligibility for Individuals

Foster Care benefits may be paid on behalf of a child only if all of the following requirements are met:

- a. Foster Care maintenance payments are allowable only if the foster child was removed from the home of a relative specified in section 406(a) of the Social Security Act, as in effect on July 16, 1996, and placed in foster care by means of a judicial determination, as defined in 42 USC 672(a)(2), or pursuant to a voluntary placement agreement, as defined in 42 USC 672(f), (42 USC 672(a)(1) and (2) and 45 CFR section 1356.21).

(1) Judicial Determination

(a) Contrary to the welfare determination – A child's removal from the home must be the result of a judicial determination to the effect that continuation in the home would be contrary to the child's welfare, or that placement in foster care would be in the best interest of the child (unless removal is pursuant to a voluntary placement agreement). The precise language "contrary to the welfare" does not have to be included in the removal court order, but the order must include language to the effect that remaining in the home will be contrary to the child's welfare, safety, or best interest (45 CFR section 1356.21(c)).

- (i) Prior to March 27, 2000 – For a child who entered foster care before March 27, 2000, the judicial determination of contrary to the welfare must be in a court order that resulted from court proceedings that are initiated no later than 6 months from the date the child is removed from the home, consistent with Departmental Appeals Board Decision Number 1508 (DAB 1508). The Departmental Appeals Board, through Decision Number 1508, ruled that a petition to the court stating the reason for the State agency's request for the child's removal from home, followed by a court order granting custody to the State agency is sufficient to meet the contrary to the welfare requirement (Federal Register, January 25, 2000, Vol. 65, Number 16, pages 4020 and 4088-89).

- (ii) On or after March 27, 2000 – For a child who enters foster care on or after March 27, 2000, the judicial determination of contrary to the welfare must be in the first court ruling that sanctions the child’s removal from home. Acceptable documentation is a court order containing a judicial determination regarding contrary to the welfare or a transcript of the court proceedings reflecting this determination (45 CFR section 1356.21(c)).
 - (b) Removal from home of a specified relative - Within 60 days from the date of the removal from home pursuant to 45 CFR section 1356.21(k)(ii), there must be a judicial determination as to whether reasonable efforts were made or were not required to prevent the removal (e.g., child subjected to aggravated circumstances such as abandonment, torture, chronic abuse, sexual abuse, parent convicted of murder or voluntary manslaughter or aiding or abetting in such activities) (45 CFR sections 1356.21(b)(1) and (k)).
 - (i) Prior to March 27, 2000 – For a child who entered care foster care before March 27, 2000, the judicial determination that reasonable efforts were made to prevent removal or that reasonable efforts were made to reunify the child and family satisfies the reasonable efforts requirement (Federal Register: January 25, 2000, Vol. 65, Number 16, pages 4020 and 4088).
 - (ii) On or after March 27, 2000 – For a child who enters foster care on or after March 27, 2000, the judicial determination that reasonable efforts were made to prevent removal or were not required must be made no later than 60 days from the date of the child’s removal from the home (45 CFR section 1356.21(b)(1)).
 - (c) Permanency plan - A judicial determination regarding reasonable efforts to finalize the permanency plan must be made within 12 months of the date on which the child is considered to have entered foster care and at least once every 12 months thereafter while the child is in foster care. If a judicial determination regarding reasonable efforts to finalize a permanency plan is not made within this timeframe, the child is ineligible at the end of the 12th month from the date the child was considered to have entered foster care or at the end of the month in which the subsequent judicial determination of reasonable efforts was due, and the child remains ineligible until such a judicial determination is made (45 CFR section 1356.21(b)(2)).
 - (i) Prior to March 27, 2000 - For a child who entered foster care before March 27, 2000, the judicial determination of reasonable efforts to finalize the permanency plan must be made no later than March 27, 2001, because such child will have been in care for 12 months or longer (January 25, 2000, Federal Register, Vol. 65, Num 16, pages 4020 and 4088).
 - (ii) On or after March 27, 2000 - For a child who enters foster care on or after March 27, 2000, the judicial determination of reasonable efforts to finalize the permanency plan must be made no later than 12 months from the date the child is considered to have entered Foster Care (45 CFR section 1356.21(b)(2)).
- (2) If the removal was by a voluntary placement agreement, it must be followed within 180 days by a judicial determination to the effect that such placement is in the best interests of the child (42 USC 672(e); 45 CFR section 1356.22(b)).
 - b. The child’s placement and care are the responsibility of either the State agency administering the approved Title IV-E plan or any other public agency under a valid agreement with the cognizant State agency (42 USC 672(a)(2)).
 - c. A child must meet the eligibility requirements of the former Aid to Families with Dependent Children (AFDC) program (i.e., meet the State-established standard of need as of July 16, 1996, prior to enactment of the Personal Responsibility and Work Opportunity Reconciliation Act) (42 USC 672(a)). Unless the child is expected to graduate from a secondary educational, or an equivalent vocational or technical training, institution before his or her 19th birthday, eligibility ceases at the child’s 18th birthday (45 CFR section 233.90(b)(3)).
 - d. The provider, whether a foster family home or a child-care institution must be fully licensed by the proper State Foster Care licensing authority. A child care institution is defined as a private child-care institution, or a public child-care institution which

- accommodates no more than 25 children, which is licensed or approved by the State in which it is situated, but does not include detention facilities, forestry camps, training schools, or facilities operated primarily for the purpose of detention of children who are determined to be delinquent (42 USC 671(a)(10) and 672(c)).
- e. The foster family home provider must satisfactorily have met a criminal records check, including a fingerprint-based check, with respect to prospective foster and adoptive parents (42 USC 671(a)(20)(A)). The requirement for a fingerprint-based check takes effect on October 1, 2006 unless prior to September 30, 2005 the State has elected to opt out of the criminal records check requirement or State legislation is required to implement the fingerprint-based check, in which case a delayed implementation is permitted until the first quarter of the State's regular legislative session following the close of the first regular session beginning after October 1, 2006. The requirement applies to foster care maintenance payments for calendar quarters beginning on or after the State's effective date for implementation (Pub. L. No. 109-248, section 152(c)(1) and (3)). The criminal records check option, including fingerprint-based checks, expires on October 1, 2008 and applies to foster care maintenance payments for calendar quarters beginning on or after that date (42 USC 671(a)(20)(B); Pub. L. No. 109-248, section 152(c)(2)).
 - f. The foster family home provider must satisfactorily have met a child abuse and neglect registry check with respect to prospective foster and adoptive parents and any other adult living in the home who has resided in the provider home in the preceding 5 years. This requirement takes effect on October 1, 2006 unless the State requires legislation to implement the requirement, in which case a delayed implementation is permitted until the first quarter of the State's regular legislative session following the close of the first regular session beginning after October 1, 2006. The requirement applies to foster care maintenance payments for calendar quarters beginning on or after that date. (42 USC 671(a)(20)(C); Pub. L. No. 109-248, section 152(c)(2) and (3)).
 - g. The licensing file for the child-care institution must contain documentation that verifies that safety considerations with respect to staff of the institution have been addressed (45 CFR section 1356.30(f)).

WAC 388-25-0075: To whom does the department make payment for foster care?

- (1) The department makes foster care payments only to persons and agencies the department has appropriately licensed and approved, or, if not subject to licensing, the department has certified as meeting the department's licensing requirements, or:
 - (a) If in another state, persons or agencies meeting the requirements of that state; or
 - (b) If in a tribal program, persons or agencies meeting the requirements of that tribal program.
- (2) The department makes payment for out-of-state foster care placements only after approval from the two state offices involved (see WAC 388-25-0440).
- (3) The department may make foster care payments to licensed or certified foster parents and to persons granted dependency guardianship, if the dependency guardians are licensed or certified as foster parents (see RCW 13.34.234).

WAC 388-25-0395: What are the department's responsibilities for management of juvenile records?

The department must comply with the requirements of chapter 13.50 RCW for management of juvenile records. The department's responsibilities for management of those records are:

- (1) To maintain accurate information and remove or correct false or inaccurate information;
- (2) To take reasonable steps to ensure the security of records and to prevent tampering;
- (3) To make every effort to ensure the completeness of records, including action taken by other agencies with respect to matters in its files; and
- (4) To facilitate inquiries concerning access to records.

Title IV-E Desk Guide:

Fully Licensed Status

- Title IV-E reimburses the State only for the costs of otherwise reimbursable children who are placed in fully licensed foster homes or facilities. Provisional, initial probationary, or initial licenses for foster homes or facilities do not meet Title IV-E requirements

Out Of State Placements

- For children in out-of-state placements for whom CA is paying foster care, the foster home must meet the receiving state's full licensing standards. Licensing or certification documentation from the receiving state is required (a letter stating only that the home is eligible to be certified is not sufficient). This documentation must be received yearly if the documents do not have an expiration date.

Eligibility ends when:

- CA fails to obtain at least one judicial finding within 180 days of the date the child was placed in foster care that says it is contrary to the welfare of the child to return home or that it is in the best interest of the child to remain in placement for a child who came into care as the result of a voluntary placement agreement.
- The foster parent or a relative of specified degree becomes the child's legal guardian pursuant to RCW 13.34.231.
- Third party custody is established under RCW 26.10.
- The child reaches the age of 18, or 19 if a full-time student who is reasonably expected to complete secondary school or an equivalent level of vocational or technical training before the end of the month of their 19th birthday. Eligibility continues to the end of the month in which the child turned 18 or 19.
- The child returns to the removal home, excluding trial home visits or trial return home as stated in the child's case plan (ISSP) or a court order, and the parent resumes daily care and control of the child.
- The child is placed with a biological, adoptive or step parent or legal guardian, excluding trial home visits or trial return home as stated in the child's case plan (ISSP) or a court order, and this party assumes daily care and control of the child. The exception to the step parent placement ending eligibility is when the step parent is divorced or legally separated from the child's bio-parent. The step parent in this case is considered a non-parental relative of specified degree. Placement with this party or the spouse of the divorced step parent is considered a relative placement event.
- A child was eligible solely due to the Rosales vs. Thompson Ninth Circuit Court Decision (August 2003 - February 8, 2006), and during the month that the first regularly scheduled review was conducted after the Deficit Reduction Act of 2005 was signed into law on 02/08/2006, it was determined that the child would not have otherwise qualified for Title IV-E in the eligibility month had non-Rosales rules been applied. Eligibility continued to the end of the month in which said review was conducted.

Documentation

File Construction

At a minimum, assemble completed hard copy documentation as follows, affixed to the right hand side of the financial revenue file from top to bottom:

- Colored sheet of paper separating each eligibility review/eligibility determination
- Title IV-E Summary Report (or for determinations prior to the GUI IV-E Tool, DSHS 14-293, -297, or -298)
- Voluntary placement agreement or flagged court order that contains the initial required contrary to welfare and reasonable efforts language highlighted

- Flagged court order that contains the required reasonable efforts to finalize the permanency plan in effect language highlighted
- Computer printouts used to support eligibility decision (ACES, SEMS, etc.) annotated so the reader can understand the meaning of each printout
- Other documentation used to support the eligibility/reimbursability decision annotated so the reader can understand the meaning of each document
- DSHS Family Face Sheet and DSHS 14-281 if in use in your region

09-14 The Department of Social and Health Services, Children's Administration, is not following established internal controls to ensure the eligibility of clients receiving adoption assistance payments.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: 93.659 Adoption Assistance
93.659 Adoption Assistance, American Reinvestment and Recovery Act (ARRA)
Federal Award Number: N/A
Applicable Compliance Component: Eligibility
Questioned Cost Amount: \$156,302

Background

The federal Adoption Assistance program provides money to states for parents who adopt children with special needs. The Children's Administration of the Department of Social and Health Services (DSHS) administers the state program from six regional offices with staffing from an adoption support program specialist. Approximately 12,000 children are in the Adoption Assistance program in the state.

The Department paid approximately \$61.4 million in adoption assistance payments in fiscal year 2009. We examined 55 cases representing \$84,926.17 in payments.

In our audit of fiscal year 2008, we reported the Department was not following internal controls regarding the eligibility of clients to receive adoption assistance payments.

Description of Condition

In response to the 2008 audit finding, the Department stated it would train all adoption support staff on how to determine eligibility. The Department also stated it would begin quarterly spot checks of current adoption support files to verify that guidelines were being followed.

During our current audit, we found the Department instituted the spot checks in the regional office identified in the previous year's finding, but not in the other regions.

We reviewed case files for 35 adopted children to determine if they met eligibility requirements and that payments were properly supported. Our selection of the files was based on the type of payment made (monthly maintenance or lump sum), the amount, and the age of the child.

We identified eight case files that did not include sufficient documentation to support eligibility or to show why a payment was made. We noted:

- Five case files showed no evidence of having been reviewed at least every five years as required by state law.
- Two case files showed no evidence of having been reviewed on or before the date required on the Revised Adoption Support Agreement.
- Three case files did not include support showing adopted children over age 18 were still in school and were entitled to receive adoption support assistance.

Payments associated with these case files totaled \$148,921.

We noted these issues at the same regional office identified in the 2008 finding.

At two other regions, we noted:

- One case file showed no evidence of having been reviewed at least once every five years as required by state law.
- One case file showed no evidence of having been reviewed on or before the date required on the Revised Adoption Support Agreement.

Payments associated with these case files totaled \$7,381.

Based on this, we expanded our work at these office to an additional 10 case files each and found no issues with those files.

Cause of Condition

The Department does not have adequate controls to ensure payments for adoption assistance are allowable and that adoption case files are complete and accurate. Department management did not sufficiently monitor to ensure payments were properly supported and made only to eligible clients. It did not ensure staff was adequately trained. The Department stated the region with the high error rate experienced significant employee turnover in July of 2006. The Department since has instituted quarterly spot checks, but the frequency of monitoring payments and updating case files has not improved

Effect of Condition and Questioned Costs

The Department made assistance payments that were unsupported or unallowable. We are questioning \$156,302.32 in payments. The weaknesses identified increase the risk of additional inappropriate payments without detection.

Recommendation

We recommend the Department:

- Follow established internal controls for monitoring case files to ensure eligibility is met and that payments are fully supported.
- Communicate with the federal grantor to determine whether questioned costs need to be repaid.

Department's Response

The Department partially concurs with the finding.

Monitoring of cases for children turning 18 is an area where the Department is currently trying to improve. The Department does not agree with attaching questioned costs to cases where a scheduled review has not been done. The intent of a 5 year review is not to verify eligibility, but to touch base with the adoptive parent and re-visit their adoption agreement. There is no risk in overpayments associated with a 5 year review.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

RCW 74.13.118: Review of support payments (statute in effect during fiscal year but subsequently amended and recodified).

At least once every five years, the secretary shall review the need of any adoptive parent or parents receiving continuing support pursuant to RCW 26.33.320 and 74.13.100 through 74.13.145, or the need of any parent who is to receive more than one lump sum payment where such payments are to be spaced more than one year apart.

At the time of such review and at other times when changed conditions, including variations in medical opinions, prognosis and costs, are deemed by the secretary to warrant such action, appropriate adjustments in payments shall be made based upon changes in the needs of the child, in the adoptive parents' income, resources, and expenses for the care of such child or other members of the family, including medical and/or hospitalization expense not otherwise covered by or subject to reimbursement from insurance or other sources of financial assistance.

Any parent who is a party to such an agreement may at any time in writing request, for reasons set forth in such request, a review of the amount of any payment or the level of continuing payments. Such review shall be begun not later than thirty days from the receipt of such request. Any adjustment may be made retroactive to the date such request was received by the secretary. If such request is not acted on within thirty days after it has been received by the secretary, such parent may invoke his rights under the hearing provisions set forth in RCW 74.13.127.

RCW 13.50.010: Definitions — Conditions when filing petition or information — Duties to maintain accurate records and access.

- (1) For purposes of this chapter:
 - (a) "Juvenile justice or care agency" means any of the following: Police, diversion units, court, prosecuting attorney, defense attorney, detention center, attorney general, the legislative children's oversight committee, the office of [the] family and children's ombudsman, the department of social and health services and its contracting agencies, schools; persons or public or private agencies having children committed to their custody; and any placement oversight committee created under RCW 72.05.415;
 - (b) "Official juvenile court file" means the legal file of the juvenile court containing the petition or information, motions, memorandums, briefs, findings of the court, and court orders;
 - (c) "Records" means the official juvenile court file, the social file, and records of any other juvenile justice or care agency in the case;
 - (d) "Social file" means the juvenile court file containing the records and reports of the probation counselor.
- (2) Each petition or information filed with the court may include only one juvenile and each petition or information shall be filed under a separate docket number. The social file shall be filed separately from the official juvenile court file.
- (3) It is the duty of any juvenile justice or care agency to maintain accurate records. To this end:
 - (a) The agency may never knowingly record inaccurate information. Any information in records maintained by the department of social and health services relating to a petition filed pursuant to chapter 13.34 RCW that is found by the court to be false or inaccurate shall be corrected or expunged from such records by the agency;
 - (b) An agency shall take reasonable steps to assure the security of its records and prevent tampering with them; and
 - (c) An agency shall make reasonable efforts to insure the completeness of its records, including action taken by other agencies with respect to matters in its files.
- (4) Each juvenile justice or care agency shall implement procedures consistent with the provisions of this chapter to facilitate inquiries concerning records.
- (5) Any person who has reasonable cause to believe information concerning that person is included in the records of a juvenile justice or care agency and who has been denied access to those records by the agency may make a motion to the court for an order authorizing that person to inspect the juvenile justice or care agency record concerning that person. The court shall grant the motion to examine records unless it finds that in the interests of justice or in the best interests of the juvenile the records or parts of them should remain confidential.
- (6) A juvenile, or his or her parents, or any person who has reasonable cause to believe information concerning that person is included in the records of a juvenile justice or care agency may make a motion to the court challenging the accuracy of any information concerning the moving party in the record or challenging the continued possession of the record by the agency. If the court grants the motion, it shall order the record or information to be corrected or destroyed.
- (7) The person making a motion under subsection (5) or (6) of this section shall give reasonable notice of the motion to all parties to the original action and to any agency whose records will be affected by the motion.
- (8) The court may permit inspection of records by, or release of information to, any clinic, hospital, or agency which has the subject person under care or treatment. The court may also permit inspection by or release to individuals or agencies, including juvenile justice advisory committees of county law and justice councils, engaged in legitimate research for educational, scientific, or public purposes. The court may also permit inspection of, or release of information from, records which have been sealed pursuant to *RCW 13.50.050(11). The court shall release to the sentencing guidelines commission records needed for its research and data-gathering functions under RCW 9.94A.850 and other statutes.

Access to records or information for research purposes shall be permitted only if the anonymity of all persons mentioned in the records or information will be preserved. Each person granted permission to inspect juvenile justice or care agency records for research purposes shall present a notarized statement to the court stating that the names of juveniles and parents will remain confidential.

- (9) Juvenile detention facilities shall release records to the sentencing guidelines commission under RCW 9.94A.850 upon request. The commission shall not disclose the names of any juveniles or parents mentioned in the records without the named individual's written permission.
- (10) Requirements in this chapter relating to the court's authority to compel disclosure shall not apply to the legislative children's oversight committee or the office of the family and children's ombudsman.

WAC 388-27-0275: When does the department review an adoption support agreement?

- (1) The adoption support program must review an agreement:
 - (a) At least once every five years; or
 - (b) When the adoptive parents request a change in the terms of the agreement.
- (2) The department may review an adoption support agreement:
 - (a) Whenever variations in medical opinions, prognosis, or costs warrant a review; or
 - (b) At the department's request.

WAC 388-27-0135 What are the eligibility criteria for the adoption support program?

For a child to be eligible for participation in the adoption support program, the department must first determine that adoption is the most appropriate plan for the child. If the department determines that adoption is in the child's best interest, the child must:

- (1) Be less than eighteen years old when the department and the adoptive parents sign the adoption support agreement;
- (2) Be legally free for adoption;
- (3) Have a "special needs" factor or condition according to the definition in this rule (see WAC 388-27-0140); and
- (4) Meet at least one of the following criteria:
 - (a) Is in state-funded foster care or child caring institution or was determined by the department to be eligible for and likely to be so placed (For a child to be considered "eligible for and likely to be placed in foster care" the department must have opened a case and determined that removal from the home was in the child's best interest.); or
 - (b) Is eligible for federally funded adoption assistance as defined in Title IV-E of the Social Security Act, the Code of Federal Regulations, the U.S. Department of Health and Human Services establishing guidelines for states to use in determining a child's eligibility for Title IV-E adoption assistance.

WAC 388-27-0210: Under what circumstances would the adoption support agreement be terminated?

The adoption support agreement is terminated according to the terms of the agreement or if any one of the following events occurs:

- (1) The child reaches eighteen years of age; (if a child is at least eighteen but less than twenty-one years old and is a full-time high school student or working full time toward the completion of a GED (high school equivalency) certificate and continues to receive financial support from the adoptive parent(s), the department may extend the terms of the adoption support agreement until the child completes high school or achieves a GED. Under no circumstances may the department extend the agreement beyond the child's twenty first birthday.) Adoption support benefits will automatically stop on the child's eighteenth birthday unless the parent(s) requests continuation per this rule and have provided documentation of the child's continuation in school. To prevent disruption in services the parent should contact the adoption support program at least ninety days prior to the child's eighteenth birthday if continued services are to be requested.
- (2) The adoptive parents no longer have legal responsibility for the child;

- (3) The adoptive parents are no longer providing financial support for the child;
- (4) The child dies; or
- (5) The adoptive parents die. (A child who met federal Title IV-E eligibility criteria for adoption assistance will be eligible for adoption assistance in a subsequent adoption.)

Children's Administration Operations Manual

13100. Records Management and Security

State law requires that CA maintain records for services to children and their families as well as for licensed or approved providers and for persons who apply and are subsequently denied licensure or approval for service. RCW 13.34.130; RCW 13.50.010; RCW 26.33.330; RCW 26.44.030

CA will maintain these records in two formats:

- Automated format in the State of Washington's State Automated Child Welfare Information System (SACWIS) called FamLink.
- Paper records linked to cases in the FamLink system.

The following table identifies tasks and procedures to be completed in FamLink and staff responsible for their completion. The table will be updated as needed to reflect changes in FamLink.

13700. Record Accuracy, Privacy, and Disclosure

This section addresses maintenance of accurate records, personal privacy, and disclosure and nondisclosure of CA records, including licensing records.

These topics are inter-related, with accuracy of information being a significant element.

13710. Expectations for Accuracy

Information in social service records must be complete and accurate, to the best ability of assigned social work or other staff, and can be shared only with authorized representatives of public or private agencies having a legitimate need to be informed concerning clients whom they are actively serving.

The Regional Administrator and the Regional Manager are responsible, in their respective areas, for the integrity of data in electronic and paper files.

Title IV-E Desk Guide: Documentation File Construction

At a minimum, assemble completed hard copy documentation as follows, affixed to the right hand side of the financial revenue file from top to bottom:

- Colored sheet of paper separating each eligibility review/eligibility determination
- Title IV-E Summary Report (or for determinations prior to the GUI IV-E Tool, DSHS 14-293, -297, or -298)
- Voluntary placement agreement or flagged court order that contains the initial required contrary to welfare and reasonable efforts language highlighted
- Flagged court order that contains the required reasonable efforts to finalize the permanency plan in effect language highlighted
- Computer printouts used to support eligibility decision (ACES, SEMS, etc.) annotated so the reader can understand the meaning of each printout
- Other documentation used to support the eligibility/reimbursability decision annotated so the reader can understand the meaning of each document
- DSHS Family Face Sheet and DSHS 14-281 if in use in your region

09-15 The Department of Social and Health Services’ internal controls are inadequate to ensure it refunds the appropriate amount to the federal Medicaid program when overpayments to providers are found.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care Providers and Suppliers
93.778 Medical Assistance Program (Medicaid; Title XIX)
93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number: 5-0905WA5028, 5-0905W5048, 5-0905WAARRA
Applicable Compliance Component: Matching
Questioned Cost Amount: None

Background

Authorized by Title XIX of the Social Security Act, Medicaid is a program jointly financed by the federal and state governments. The states submit a comprehensive written plan that describes the nature and scope of their programs to the Center for Medicare and Medicaid Services (CMS). If the plan is approved, the federal government pays a share of the medical assistance expenditures, known as the Federal Medical Assistance Percentage (FMAP). The amount is determined annually by a formula that compares a state's average per capita income with the national income average. All states receive at least a 50 percent match, but states with a higher per capita income level are reimbursed a smaller share of their costs above 50 percent.

For the past several years, Washington state’s FMAP has been close to 50 percent (from 50 percent in fiscal year 2006 to 51.52 percent in fiscal year 2008). Actions taken through the American Recovery and Reinvestment Act of 2009 (ARRA) made temporary modifications to the state FMAP calculation, increasing the fiscal year 2009 FMAP from 50.94 percent to 61.58 percent.

When an unallowable payment to a Medicaid service provider, known as an ‘overpayment’, is discovered, the state is required to refund the federal grantor its share of the overpayment.

Description of Condition

The Department has been reimbursing the federal grantor at the wrong FMAP rate for provider overpayments. We noted the Department’s Medicaid Management Information System (MMIS) automatically applies the current FMAP rate to all prior period adjustments regardless of when the original payment occurred. While this condition would have had a relatively minor effect in prior years due to the consistency of the FMAP rate, the advent of ARRA means the Department has been reimbursing the federal grantor far more than it is entitled to for overpayments occurring in prior periods.

Cause of Condition

The Department stated its automated system is not capable of identifying the correct FMAP for prior year adjustments.

Effect of Condition

We selected one type of claim payment, including most Medicaid provider services, that accounted for approximately 77 percent of the total Medicaid payments in fiscal year 2009. We identified prior period credit adjustments for this type of claim that were processed with the current FMAP rate. We then estimated the amounts the Department over-refunded to the federal government.

We found the Department over-refunded approximately \$1.4 million to the federal government.

Total Paid	Federal share refunded (based on increased fiscal year 2009 FMAP) ¹	Federal share should have been refunded (Based on FMAP ² of the original payment)	Over-refunded
\$13,027,474	\$7,962,392	\$6,585,388	\$1,377,004 ³

¹ The federal share refunded is calculated by using 61.58 percent, which is the average of increased ARRA FMAP in fiscal year 2009.

² The federal share that should have been refunded is calculated by using 50.55 percent, which is the average of regular FMAP for FY 2006, 2007 and 2008.

³ This calculation used information from “Washington State’s Enterprise Reporting Standard Reports” system which summarizes detailed MMIS transaction information.

Recommendation

We recommend the Department:

- Establish procedures to ensure the correct FMAP rate is used for all adjustments and refunds to the federal government are accurate.
- Reprocess all adjustments that were refunded at the inappropriate FMAP rate and work with the federal grantor to collect the amount owed the state.

Additional Information

During the course of our review we also selected two types of payments related to Home and Community Based waiver services administered by the Aging and Disability Services Administration (ADSA). The two payment types accounted for approximately 14 percent of total Medicaid payments in fiscal year 2009. Using the same procedures as above, we determined the Department over-refunded approximately \$72,000 to the Federal government.

Total paid	Federal share refunded (based on increased FY09 FMAP) ¹	Federal share based on original payment year FMAP ²	Over-refunded
\$680,690	\$416,038	\$344,089	\$71,949 ³

¹ The federal share refunded is calculated by using 61.58 percent, which is the average of increased ARRA FMAP in fiscal year 2009.

² The federal share that should have been refunded is calculated by using 50.55 percent, which is the average of regular FMAP for FY 2006, 2007 and 2008.

³ This calculation used information from “Washington State’s Enterprise Reporting Standard Reports” system which summarizes detailed MMIS transaction information.

We included this exception because it is a known error and represents funding the state could potentially recover. At this time we are not able to determine the cause of the exception.

Department’s Response

This is a combined finding involving the Aging and Disability Services Administration (ADSA) and the Health and Recovery Services Administration (ADSA). Both administrations concur with this finding.

Auditor’s Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department’s corrective action during our next audit.

Applicable Laws and Regulations

Office of Management and Budget Circular A-87, Cost Principles for State, Local, and Indian Tribal Governments, states in Attachment A, Section C.4.a states:

Applicable credits refer to those receipts or reduction of expenditure-type transactions that offset or reduce expense items allocable to Federal awards as direct or indirect costs. Examples of such transactions are: purchase discounts, rebates or allowances, recoveries or indemnities on losses, insurance refunds or rebates, and adjustments of overpayments or erroneous charges. To the extent that such credits accruing to or received by the governmental unit relate to allowable costs, they shall be credited to the Federal award either as a cost reduction or cash refund, as appropriate.

1903(d) of the Social Security Act states in part:

- (d)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a) and (b) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.
- (2)(A) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.
- (B) Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1902(a)(25).
- (C) For purposes of this subsection, when an overpayment is discovered, which was made by a State to a person or other entity, the State shall have a period of 60 days in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. Except as otherwise provided in subparagraph (D), the adjustment in the Federal payment shall be made at the end of the 60 days, whether or not recovery was made.
- (D) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity on account of such debt having been discharged in bankruptcy or otherwise being uncollectable, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof).

CFR42 § 433.10 Rates of FFP for program services.

- (a) Basis. Sections 1903(a)(1), 1903(g), and 1905(b) provide for payments to States, on the basis of a Federal medical assistance percentage, for part of their expenditures for services under an approved State plan.
- (b) Federal medical assistance percentage (FMAP)—Computations. The FMAP is determined by the formula described in section 1905(b) of the Act.

§ 433.312 Basic requirements for refunds.

(a) *Basic rules.*

- (1) Except as provided in paragraph (b) of this section, the Medicaid agency has 60 days from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to CMS.
- (2) The agency must refund the Federal share of overpayments at the end of the 60-day period following discovery in accordance with the requirements of this subpart, whether or not the State has recovered the overpayment from the provider.

(b) *Exception.* The agency is not required to refund the Federal share of an overpayment made to a provider when the State is unable to recover the overpayment amount because the provider has been determined bankrupt or out of business in accordance with §433.318.

(c) *Applicability.*

- (1) The requirements of this subpart apply to overpayments made to Medicaid providers that occur and are discovered in any quarter that begins on or after October 1, 1985.
- (2) The date upon which an overpayment occurs is the date upon which a State, using its normal method of reimbursement for a particular class of provider (e.g., check, interfund transfer), makes the payment involving unallowable costs to a provider.

09-16 The Department of Social and Health Services did not have adequate controls to ensure it complied with federal requirements for allocating employee salaries and wages and other administrative costs in accordance with its Public Assistance Agency Cost Allocation Plan.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: 93.778 Medical Assistance Program
93.778 Medical Assistance Program (Medicaid; Title XIX) –
American Recovery and Reinvestment Act (ARRA)
Federal Award Number: Multiple
Applicable Compliance Component: Allowable Costs/Cost Principles
Questioned Cost Amount: \$12,163,750

Background

Federal regulations require the Department of Social and Health Services (DSHS) to prepare and administer a Public Assistance Cost Allocation Plan. The plan must describe procedures the Department uses to identify, measure and allocate all direct and indirect costs for each program it administers. The Plan must be approved by the federal grantors.

Cost allocation bases are used to accumulate and distribute administrative costs to the benefitting federal programs. These distributions may be based on caseloads, number of employees, employee time and activity reports, or other reasonable criteria.

The DSHS-approved cost allocation plan states the Economic Services Administration uses a specific cost allocation base, identified by the Department as base 476, to accumulate and allocate the salaries, benefits, building lease, goods and services and travel costs of Regional and Community Service Offices administrative staff. The Regional and Community Service offices provide services paid for by several different federal grants and this allocation base is to be used to distribute the costs equitably to the programs, which include Medicaid, the Supplemental Nutrition Assistance Program, Temporary Assistance to Needy Families, Refugee and Entrant Assistance, as well as a number of state funded programs. For the fiscal year ended June 30, 2009, the state allocated approximately \$58.7 million to various federal and state funding sources through base 476.

Description of Condition

The Economic Services Administration claimed federal reimbursement for costs allocated through allocation base 476 from May through August 2009 that did not comply with the cost allocation methodologies described in its approved Plan or federal Office of Management and Budget (OMB) Circular A-87.

During our audit, we found the Department had incorrectly allocated all costs charged to base 476 from May through August 2009 solely to the Medicaid program. After we found this misallocation in September, the Department provided evidence that it was in the process of correcting the error.

Cause of Condition

Staff responsible for preparing quarterly updates to the automated cost allocation system did not include all appropriate coding to ensure the base 476 was updated correctly in April 2009. Staff responsible for reviewing the update to this base was new to the position and did not identify the errors until four months after they were made.

Effect of Condition and Questioned Costs

When a public assistance agency charges federal programs outside of the methods approved in the Plan, federal grantors cannot be assured costs allocated to their programs are accurate and valid. In this instance, the Medicaid program was charged for costs that should have been charged to other programs.

We are questioning the following costs \$12,163,750 in costs allocated to the Medicaid program.

Half of this, or \$6,081,875, was the federal share of the incorrect charges. The other half was paid for with state dollars.

The Department stated that it has made corrections to repay the \$12,163,750 inappropriately allocated to the Title XIX program.

Recommendation

We recommend DSHS:

- Establish procedures to ensure all updates to cost allocation bases are updated consistent with the approved Public Assistance Cost Allocation Plan and OMB Circular A-87.
- Work with its grantor to ensure costs repaid to the Medicaid program meet with grantor approval, including interest as applicable.

Department's Response

The Department partially concurs with this finding.

The Department agrees that costs associated with Base 476 were incorrectly allocated from May through August 2009, but does not concur with the questioned costs of \$12,163,750. The Department realized the error on August 18, 2009, and took action to correct the misallocation of funds. The base information was updated immediately and correcting journal vouchers were processed by the end of September 2009 before the federal claim was processed.

Written procedures have been developed and are in place to mitigate the occurrence of future cost allocation base update errors. The procedure requires an internal review, by an Economic Services Administration (ESA) fiscal staff person, of cost allocation forms used to update base information prior to submission to the Office of Accounting Services for input. The procedure also requires an internal review of the information entered in to the automated cost allocation system to determine if the information was input accurately.

After the Statewide Single Audit has been completed and distributed at the federal level, federal agencies review the findings and contact the Department to determine if any questioned costs need to be adjusted or repaid.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable laws and Regulations

Title 45 Code of Federal Regulations, Subtitle A (10-1-03 Edition), Section 95.507 - Plan Requirements, sub-section (b.8) states in part:

... an adequate accounting and statistical system exists to support claims that will be made under the cost allocation plan.

Plan requirements.

(a) The State shall submit a cost allocation plan for the State agency as required below to the Director, Division of Cost Allocation (DCA), in the appropriate HHS Regional Office. The plan shall:

- (1) Describe the procedures used to identify, measure, and allocate all costs to each of the programs operated by the State agency...
- (4) The procedures used to identify, measure, and allocate all costs to each benefiting program and activity (including activities subject to different rates of FFP).

Section 95.517 - Claims for Federal Financial Participation, sub-section (a) states in part:

A State must claim FFP for costs associated with a program only in accordance with its approved cost allocation plan.

The U.S. Office of Management and Budget's Circular A-87, Cost Principles for State, Local and Indian Tribal governments provides in:

Attachment A, Section C.3 of the Circular requires allocable costs to be chargeable or assignable in accordance with the relative benefits received.

09-17 The Department of Social and Health Services, Aging and Disability Services Administration, does not have adequate controls in place to ensure all assets applicants own are counted when Medicaid eligibility is determined.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care Providers and Suppliers
93.778 Medical Assistance Program (Medicaid; Title XIX)
93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number: 5-0905WA5028, 5-0905W5048, 5-0905WAARRA
Applicable Compliance Component: Eligibility
Questioned Cost Amount: None

Background

The Medicaid program covers long-term care services for individuals who are unable to afford it. In order to ensure the availability of long-term care services for people who truly need them, the federal Deficit Reduction Act of 2005 tightened Medicaid asset transfer rules to make it more difficult for individuals with resources to pay for their own long-term care to inappropriately transfer assets for less than fair market value in order to qualify for Medicaid.

When an individual applies for Medicaid coverage for long-term care, the state conducts a review, or “look-back” to determine whether the individual (or his or her spouse) transferred assets to another person or party for less than fair market value to become eligible for Medicaid. The Act lengthened the “look-back period” to 60 months (five years) prior to the date the individual applies for Medicaid.

When individuals transfer assets at less than fair market value in order to qualify for Medicaid long-term care services, the individual is subject to a penalty that delays the date he or she can qualify to receive Medicaid long-term care services. Under the Act, the penalty period for transfers made on or after February 8, 2006, begins on either the date of the asset transfer, or the date the individual is found eligible for Medicaid coverage, whichever is later.

In our audit for fiscal year 2008 we reported a finding relating to the Department’s inadequate controls over the “look-back period” review.

Description of Condition

During our current audit, we found no changes in the conditions that we reported in our audit of fiscal year 2008. The Department relies on self declaration by the client for any asset transfers or sales within the five-year look back period.

Financial documents the Department reviews do not provide a reasonable picture of the applicant’s financial situation over the five year look-back period.

Cause of Condition

The Department does not agree that federal rules require verification of financial statements for the previous five years, unless a transfer has been declared or there are inconsistent facts in the record or other problems with the application.

Effect of Condition

Lack of adequate procedures to identify the financial resources of applicants when Medicaid eligibility is determined increases the risk of ineligible individuals receiving long-term care through the Medicaid program.

Recommendation

We recommend the Department establish and follow internal controls that will reasonably ensure all assets applicants own during the look-back period are countable when Medicaid eligibility is determined.

Department's Response

The Department does not concur with this finding.

The Department disagrees with the SAO for the following reasons:

- *Most clients do not have 60 months of bank statements available to provide. This is a very onerous request to make of clients, most of whom have not transferred assets in order to qualify. The process that the client or Department would have to go through to provide that much history would be lengthy and expensive, and would not meet the federal requirement in 42CFR 435.902 that an agency's policies and procedures for determining eligibility must be conducted in a manner consistent with simplicity of administration and is in the best interests of applicants and recipients.*
- *The Department would have to pay banks to provide archived statements that the clients no longer have per WAC 388-490-0005(7). The length of time it would take to request and then review a minimum of 60 bank statements, with the possibility of hundreds more if there are multiple accounts at different banks, would make it impossible to meet our standard of promptness for Medicaid applications with existing staff. Many additional FTEs would be required. Requiring all clients to provide 60 months of bank statements would not be cost-effective.*
- *Requiring clients to provide five years of bank statements would only pertain to bank accounts that are declared. No system is in place to identify undeclared bank accounts and other types of undeclared transfers which is the primary reason for reliance on self-declaration.*
- *The Department is committed to ensuring that Medicaid clients are financially eligible for the program benefits that they receive and will continue to pursue and verify any asset transfers that it becomes aware of through the written application, the subsequent interview, or discovered through other means. The Department is taking the following actions:*
 - *Staff will routinely check online county assessor systems to see if clients have transferred property within the county they reside in.*
 - *If the bank statements from the last three or six months contain payments or credits that present red flags we will look as far into this as necessary to resolve the issue.*
 - *If the client declares a transfer, staff will request and obtain verification and thoroughly evaluate that transfer to ensure that it is consistent with Medicaid rules.*
 - *If the interview is inconsistent with the application, staff will evaluate and probe inconsistencies as necessary.*
 - *If staff learn of possible transfers through other means they always follow-up and verify.*

The Department submitted policies and procedures to Region 10 CMS in June 2009. We asked them to review them and comment on whether they meet federal guidelines. We received CMS' email response December 22, 2009. The following is a direct quote from the CMS email:

"While we understand your dilemma with the State Auditor's Office on the matter of documenting 5-years of bank statement to ensure all assets of applicants during the look-back period are countable when Medicaid eligibility is determined. The CMS cannot specifically comment on the state process for conducting the 5-year look back for transfer of assets which could impact a state's flexibility in documenting and verifying these transfers. This continues to be an operational matter, states have flexibility to implement this provision according to the general "rules of reason" and to give workers procedural guidance as to how to explore or document past financial transactions that might have been asset transfers. CMS affirms the initial guidance on flexibility given to states to implement policies that provide for looking back 5 years.

The 5-year look back period only changes for transfer made after February 8, 2006, the effective date of the law. States are actively engaged in the pursuit of the asset verification systems which will provide for external

verification of the reported financial information made by applicants, until then states must have sufficient procedures to capture and verify the reported client information.

If you require any additional information please let me know.

Maria”

The Department believes this response validates our position that asking for bank statements for the entire look-back period is not required. The Department believes the methods described above meet the “rules of reason” test referred to by CMS in their email.

Auditor’s Remarks

We thank the Department for its response and commitment to continuing discussions on this issue. We agree with the Department that requesting 60 months of bank statements is a very onerous request in most cases. We expect the Department to have internal controls that will reasonably ensure all assets applicants own during the look-back period are countable when Medicaid eligibility is determined. The current internal controls the Department has cannot provide a reasonable picture of the applicant’s financial situation over the five year look-back period.

Applicable Laws and Regulations

42 United States Code section 1396p, as amended by the Deficit Reduction Act of 2005, states in part:

(c)(1)(B)(i) The look-back date specified in this subparagraph is a date that is ... (...in the case of any other disposal of assets made on or after the date of the enactment of the Deficit Reduction Act of 2005, 60 months) before the date specific in clause (ii).

(c)(1)(D)(ii) In the case of a transfer of asset made on or after the date of the enactment of the Deficit Reduction Act of 2005, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 300, states in part:

The auditee shall:

- (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.

09-18 The Department of Social and Health Services, Aging and Disability Services Administration, Home and Community Based Services Division, does not have adequate controls to ensure Medicaid recipients have received the services for which Medicaid is being billed.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-0905WA5028, 5-0905W5048, 5-0905WAARRA
Applicable Compliance Component:	Utilization Control and Program Integrity
Questioned Cost Amount:	None

Background

Federal regulations require state Medicaid agencies to have a process to verify with Medicaid clients that they received the services billed to Medicaid by providers. This process is intended to identify potential fraud or abuse of the Medicaid program.

The Medicaid program is the major source of public funding for long-term care services. The Home and Community Based Services waiver program permits states to furnish long-term care services to Medicaid beneficiaries in home and community settings, avoiding institutionalization. These service providers are chosen by the client or agencies working on behalf of the client.

The Department of Social and Health Services, Aging and Disability Services Administration (ADSA), administers long-term services and support and is responsible for instituting and following the recipient verification process.

In our audit of state fiscal year 2008, we reported a finding regarding the Department’s lack of adequate controls to ensure Medicaid payments to in-home service providers are allowable and supported.

ADSA paid more than \$427 million for in-home services during fiscal year 2009.

Description of Condition

During our current audit, we found no changes in the conditions we reported in our audit of fiscal year 2008. The Administration does not have any procedures to verify with home- and community-based service Medicaid clients whether services billed by providers were received.

Cause of Condition

The Department concurred with the finding and believes an automated process is the most cost effective way to meet the requirement. The Department states it plans to use a new Provider Compensation Subsystem in the future that would meet the service verification requirements. Due to the lack of staffing to conduct a manual process, and the planned replacement of the existing Social Services Payment System (SSPS) with the Provider Compensation Subsystem, the Department does not believe an interim automated solution is prudent or cost-effective.

Effect of Condition

The lack of appropriate, required verification increases the risk of fraudulent claims being paid and not being detected in a timely manner, if at all.

Recommendation

We recommend the Department develop and follow a method for verifying directly with recipients that they have received the services for which Medicaid is being billed.

Department's Response

The Department concurs that it does not have a process that provides Medicaid recipients with information on the number of hours billed to the Department by individual providers (IP). The Department is in the process of procuring a Provider Compensation System (PCS) that will improve the verification process. The PCS will be a sub-system of Provider One, the new Medicaid Management Information System. Specifically, the new system will generate monthly notices to all clients informing them how many hours were paid to the provider on their behalf during the previous month. The clients will be instructed to notify the Department if they notice a discrepancy in the hours provided versus the hours billed.

The new system is not expected to be implemented for approximately two years. In the meantime, the Department will rely on the following controls that are currently in place:

- Case managers complete an assessment that results in an authorization of hours that cannot be exceeded by a provider invoice.*
- Clients receive a copy of the service summary that tells them the number of hours of service they are eligible to receive. Clients are advised that they can choose when those hours are provided and direct the individual provider when to provide them. Case Managers also advise clients to contact them if they are not receiving the hours (or care) for which they are eligible.*
- Clients are expected to keep copies of timesheets for their individual providers and case managers periodically review these time sheets and verify with the client that authorized services have been provided. Case managers are instructed to document the review of time sheets and the discussion of service verification in a Service Episode Record.*
- The Department, through its Payment Review Program, runs algorithms to detect possible fraudulent claims. Overpayments are initiated and referrals are made to the Medicaid Fraud Control Unit as indicated by findings.*
- The Social Service Payment System will not process payments in excess of hours authorized. A provider is therefore unable to claim and be reimbursed for hours that exceed those authorized by the case manager.*

In September 2009, the Department completed a revision of a written communication titled "Acknowledgement of My Responsibilities As the Employer of My Individual Providers." Staff have been instructed to review this form with all clients who employ an individual provider. By October 31, 2010, the form will be reviewed with all clients who employ an IP.

Auditor's Remarks

We thank the Department for its response and assistance throughout the audit, and will review this area during our next audit.

Applicable Laws and Regulations:

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 300, states in part:

The auditee shall:

- (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.

Title 42, code of Federal Regulations, Section 455 states in part:

§ 455.1 Basis and scope.

This part sets forth requirements for a State fraud detection and investigation program, and for disclosure of information on ownership and control.

- (a) Under the authority of sections 1902(a)(4), 1903(i)(2), and 1909 of the Social Security Act, Subpart A provides State plan requirements for the identification, investigation, and referral of suspected fraud and abuse cases. In addition, the subpart requires that the State—
 - (1) Report fraud and abuse information to the Department; and
 - (2) Have a method to verify whether services reimbursed by Medicaid were actually furnished to recipients.
- (b) Subpart B implements sections 1124, 1126, 1902(a)(36), 1903(i)(2), and 1903(n) of the Act. It requires that providers and fiscal agents must agree to disclose ownership and control information to the Medicaid State agency.
- (c) Subpart C implements section 1936 of the Act. It establishes the Medicaid Integrity Program under which the Secretary will promote the integrity of the program by entering into contracts with eligible entities to carry out the activities of subpart C.

[51 FR 34787, Sept. 30, 1986, as amended at 72 FR 67655, Nov. 30, 2007]

§ 455.20 Recipient verification procedure.

- (a) The agency must have a method for verifying with recipients whether services billed by providers were received.
- (b) In States receiving Federal matching funds for a mechanized claims processing and information retrieval system under part 433, subpart C, of this subchapter, the agency must provide prompt written notice as required by §433.116 (e) and (f).

09-19 The Department of Social and Health Services, Health and Recovery Services Administration, does not comply with state law and the federal Deficit Reduction Act of 2005, thereby increasing the likelihood that the state is paying claims that should have been paid by liable third parties.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-0905WA5028, 5-0905W5048, 5-0905WAARRA
Applicable Compliance Component:	Activities Allowed/Unallowed, Allowable, Costs/Cost Principles
Questioned Cost Amount:	None

Background

Medicaid is the “payer of last resort”, meaning that other payment sources should be identified and used prior to submitting claims to Medicaid. Third-party liability refers to the legal obligation of third-party resources, usually insurance companies, to pay medical and pharmaceutical claims of Medicaid recipients prior to Medicaid coverage. The function of third-party liability within the Medicaid program is to ensure non-Medicaid resources are the primary source of payment. Federal regulations require states to have processes to identify third parties liable for payment of services before Medicaid dollars are used.

The federal Deficit Reduction Act of 2005 requires health insurers to provide states with eligibility and coverage information that will enable Medicaid agencies to determine whether Medicaid recipients have third-party coverage. The Act directs states, as a condition of receiving Medicaid money, to have laws requiring health insurers doing business in that state to provide the eligibility and coverage information upon the request of the state.

To comply with this requirement, the state Legislature passed a law (RCW 74.09A) in 2007 that requires the Department of Social and Health Services to provide Medicaid client eligibility and coverage information to insurers doing business in the state. The insurers, in turn, are required to use that information to identify Medicaid clients with third-party coverage, and provide those results to DSHS. The law requires this process to be performed no less than twice per year.

In our audit for fiscal year 2008 we reported a finding regarding the Department’s noncompliance with the state law.

The state had Medicaid expenditures of approximately \$6.8 billion in fiscal year 2009, \$4.1 billion of which was federal dollars.

Description of Condition

During our current audit, we found the Department sent a letter to all insurers doing business in the state requesting Department access to the insurer’s online eligibility and claims information. However, we found no changes in the conditions that we reported in our audit of fiscal year 2008. The Department does not provide routine and periodic computerized information to health insurers regarding client eligibility and coverage information, and it does not receive identification of joint beneficiaries in return from health insurers. The Department is still not complying with state law, and therefore also is not complying with the federal Deficit Reduction Act of 2005.

Cause of Condition

The Department states it is meeting the requirements of state law and therefore federal regulation, through work it currently performs. Although the Department indicated that its current processes were adequate, it also stated it intends to meet the requirements of the law when its new claims system, ProviderOne, becomes operational.

Effect of Condition

While the Department does have processes in place to identify third-party liability, these processes focus on the time of initial application for Medicaid benefits and on notification by care providers of potential third-party coverage. The requirements of the Act and state law, if followed, would provide for a more comprehensive and ongoing review and identification of potential third-party payers. When Medicaid-eligible individuals with third-party liability coverage are not identified, Medicaid is no longer the payer of last resort and the Department is not ensuring that third-party resources are meeting their legal obligation to pay claims.

Recommendation

We recommend the Department comply with state law and the Deficit Reduction Act of 2005 in order to better identify all third parties liable for Medicaid beneficiary claims.

Department's Response

The Department does not concur with this finding.

The Department believes it is in compliance with the Deficit Reduction Act of 2005. The Department meets this standard by making data available to all insurers to use for Third Party Liability (TPL) reporting and by matching data directly with those insurers most likely to provide third party coverage to Medicaid recipients.

The Department's position has recently been corroborated by an independent review. In November 2009, Health Management Systems (HMS) performed an assessment of the Health and Recovery Services Administration's (HRSA) Coordination of Benefits (COB) operations, including recommendations addressing applicable legislation and state statutes. HMS is currently engaged with 40 Medicaid agencies to conduct TPL identification and recoveries. HMS brings a depth of subject matter expertise in Medicaid TPL best practices as well as a thorough understanding of current technologies and capabilities within the industry. A draft of the report indicated the following points.

- *“In 2007 Washington passed Substitute House Bill 1826, updating its Medicaid data matching and recovery regulations as required by Section 6035 of the federal Deficit Reduction Act (DRA) of 2005. As a result, Washington's federal DRA compliant laws are fragmented across several sections of state statute including: Rev. Code Wash. (ARCW) 74.09A.020, 42.48, 74.09, 74.04, 70.02, and 42.56RCW”.*
- *“However, despite the fragmentation, Washington's law is compliant with the requirements set forth in the DRA and U.S.C. Sec. 1396a”.*
- *“The current state statute instructs **health insurers** to determine joint-beneficiaries – those enrolled in Medicaid and commercial carriers”.*
- *“The current language instructs DSHS to focus on the carriers with the highest probability of coverage. It does make sense for DSHS to focus efforts on carriers with large populations. However, these carriers should not be the sole focus.”*
- *“Although improvements can be made to the State's data sharing and matching laws, it should be noted that **Washington has some of the strongest recovery language in the nation.**”*

While the Department believes it meets legal requirements currently, with the implementation of the new ProviderOne system, which will replace MMIS, the Department will further enhance data matching activities. The anticipated implementation date for ProviderOne is April 2010.

When the system is implemented and the Center for Medicare and Medicaid (CMS) approves the data elements jointly agreed to by the state and insurers, HRSA will be able to send an electronic Coordination of Benefits eligibility inquiry to health plans who have signed Trading Partner Agreements with the Department. The trading partners will be able to respond electronically to eligibility inquiries to indicate the availability of third party health care coverage at a particular time. For those insurers or carriers who may not have their systems ready to participate electronically, HRSA will continue working with them using the methods currently in place.

In conclusion, as a temporary measure to increase the opportunity for data matches with providers and pending implementation of ProviderOne, in September 2009, the Department sent letters (4,024) to all active third party

payers on file in the Medicaid Management Information System (MMIS) reminding them of the Department's willingness to perform data matches.

Auditor's Remarks

We thank the Department for its commitment to enhancing data matching capabilities to ensure state and federal funds are not paying claims that should have been paid by liable third parties. We look forward to the improvements the Department intends to make upon implementation of its new payment system.

Applicable Laws and Regulations

42 United State Code 1396a(a)(25).states:

- (A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans (as defined in section 1167(1) of Title 29), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including--
 - (i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and
 - (ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1396b(r) of this title;
- (B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;
- (C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1396o of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1396o of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396o of this title), exceeds the total of the amount of the liabilities of third parties for that service;
- (D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;
- (E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1396d(a)(4)(B) of this title) covered under the State plan, the State shall--
 - (i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and
 - (ii) seek reimbursement from such third party in accordance with subparagraph (B);
- (F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of subchapter IV of this chapter, the State shall--
 - (i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished; and
 - (ii) seek reimbursement from such third party in accordance with subparagraph (B);

- (G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, a self-insured plan, a service benefit plan, a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this title for such State, or any other State;
- (H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services; and
- (I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to--
 - (i) provide, with respect to individuals who are eligible (and, at State option, individuals who apply or whose eligibility for medical assistance is being evaluated in accordance with subsection (e)(13)(D) of this section) for, or are provided, medical assistance under the State plan under this subchapter (and, at State option, child health assistance under subchapter XXI of this chapter), upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;
 - (ii) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;
 - (iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and
 - (iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if--
 - (I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and
 - (II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;

The Revised Code of Washington (RCW) 74.09A.005 states:

The legislature finds that:

- (1) Simplification in the administration of payment of health benefits is important for the state, providers, and health insurers;
- (2) The state, providers, and health insurers should take advantage of all opportunities to streamline operations through automation and the use of common computer standards;
- (3) It is in the best interests of the state, providers, and health insurers to identify all third parties that are obligated to cover the cost of health care coverage of joint beneficiaries; and
- (4) Health insurers, as a condition of doing business in Washington, must increase their effort to share information with the department and accept the department's timely claims consistent with 42 U.S.C. 1396a(a)(25).

Therefore, the legislature declares that to improve the coordination of benefits between the department of social and health services and health insurers to ensure that medical insurance benefits are properly utilized, a transfer of information between the department and health insurers should be instituted, and the process for submitting requests for information and claims should be simplified.

RCW 74.09A.020 states:

Computerized information — Provision to health insurers.

- (1) The department shall provide routine and periodic computerized information to health insurers regarding client eligibility and coverage information. Health insurers shall use this information to identify joint beneficiaries. Identification of joint beneficiaries shall be transmitted to the department. The department shall use this information to improve accuracy and currency of health insurance coverage and promote improved coordination of benefits.
- (2) To the maximum extent possible, necessary data elements and a compatible database shall be developed by affected health insurers and the department. The department shall establish a representative group of health insurers and state agency representatives to develop necessary technical and file specifications to promote a standardized database. The database shall include elements essential to the department and its population's health insurance coverage information.
- (3) If the state and health insurers enter into other agreements regarding the use of common computer standards, the database identified in this section shall be replaced by the new common computer standards.
- (4) The information provided will be of sufficient detail to promote reliable and accurate benefit coordination and identification of individuals who are also eligible for department programs.
- (5) The frequency of updates will be mutually agreed to by each health insurer and the department based on frequency of change and operational limitations. In no event shall the computerized data be provided less than semiannually.
- (6) The health insurers and the department shall safeguard and properly use the information to protect records as provided by law, including but not limited to chapters 42.48, 74.09, 74.04, 70.02, and 42.56 RCW, and 42 U.S.C. Sec. 1396a and 42 C.F.R. Sec. 43 et seq. The purpose of this exchange of information is to improve coordination and administration of benefits and ensure that medical insurance benefits are properly utilized.
- (7) The department shall target implementation of this section to those health insurers with the highest probability of joint beneficiaries.

WAC 388-501-0200 states:

- (1) MAA requires a provider to seek timely reimbursement from a third party when a client has available third-party resources, except as described under subsections (2) and (3) of this section.
- (2) MAA pays for medical services and seeks reimbursement from the liable third party when the claim is for any of the following:
 - (a) Prenatal care;
 - (b) Labor, delivery, and postpartum care (except inpatient hospital costs) for a pregnant woman; or
 - (c) Preventive pediatric services as covered under the EPSDT program.
- (3) MAA pays for medical services and seeks reimbursement from any liable third party when both of the following apply:
 - (a) The provider submits to MAA documentation of billing the third party and the provider has not received payment after thirty days from the date of services; and
 - (b) The claim is for a covered service provided to a client on whose behalf the office of support enforcement is enforcing an absent parent to pay support. For the purpose of this section, "is enforcing" means the absent parent either:
 - (i) Is not complying with an existing court order; or
 - (ii) Received payment directly from the third party and did not pay for the medical services.
- (4) The provider may not bill MAA or the client for a covered service when a third party pays a provider the same amount as or more than the MAA rate.
- (5) When the provider receives payment from the third party after receiving reimbursement from MAA, the provider must refund to MAA the amount of the:
 - (a) Third-party payment when the payment is less than MAA's maximum allowable rate; or
 - (b) MAA payment when the third-party payment is equal to or greater than MAA's maximum allowable rate.
- (6) MAA is not responsible to pay for medical services when the third-party benefits are available to pay for the client's medical services at the time the provider bills MAA, except as described under subsections (2) and (3) of this section.

- (7) The client is liable for charges for covered medical services that would be paid by the third party payment when the client either:
 - (a) Receives direct third-party reimbursement for such services; or
 - (b) Fails to execute legal signatures on insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered. See WAC 388-505-0540 for assignment of rights.
- (8) MAA considers an adoptive family to be a third-party resource for the medical expenses of the birth mother and child only when there is a written contract between the adopting family and either the birth mother, the attorney, the provider, or the adoption service. The contract must specify that the adopting family will pay for the medical care associated with the pregnancy.
- (9) A provider cannot refuse to furnish covered services to a client because of a third party's potential liability for the services.
- (10) For third-party liability on personal injury litigation claims, MAA is responsible for providing medical services as described under WAC 388-501-0100.

09-20 The Department of Social and Health Services, Health and Recovery Services Administration, does not perform a quarterly retrospective drug use review of pharmaceutical claims data to identify patterns of fraud or abuse as required by federal and state law.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care Providers and Suppliers
93.778 Medical Assistance Program
93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number: 5-0905WA5028, 5-0905W5048, 5-0905WAARRA
Applicable Compliance Component: Utilization Control and Program Integrity
Questioned Cost Amount: None

Background

Pharmaceutical claims for Medicaid client prescriptions are processed through the Point-of-Sale System (POS), which runs each request for payment through a series of criteria, known as edits, within the system. Claims are paid if they successfully pass all edits.

Federal and state laws require state Medicaid programs to have a retrospective drug use review program of pharmaceutical claims data in order to identify patterns of fraud, abuse, gross overuse or inappropriate or medically unnecessary care among physicians, pharmacists, and Medicaid recipients. Federal law requires that this examination must involve a pattern analysis, using predetermined standards, of physicians' prescribing practices, drug use by individual patients and, where appropriate, dispensing practices of pharmacies. Our audit for fiscal year 2008 reported a finding regarding the Department's noncompliance with the federal and state laws.

The Department paid more than \$475 million to pharmacies for services to Medicaid clients in fiscal year 2009.

Description of Condition

During our current audit, we found no changes in the conditions that we reported in our audit of fiscal year 2008. The Department does not perform a retrospective drug use review involving pattern analysis for the purpose of identifying fraud or abuse.

Cause of Condition

The Department does review drug utilization for the purpose of analyzing the clinical quality of prescribing and dispensing. It believes this review is sufficient to fulfill the requirements of federal and state laws.

Effect of Condition

The Department is not using available resources to identify patterns of fraud, abuse, and misuse of pharmaceutical claims paid with Medicaid funds, increasing the risk these situations could occur and not be detected in a timely manner.

Recommendation

We recommend the Department establish controls to comply with federal and state laws and to identify patterns of fraud, abuse, and misuse of pharmaceuticals paid for with Medicaid funds.

Department's Response

The Department does not concur with this finding.

Title 42 CFR stipulates the department must perform quarterly retrospective Drug Utilization Review (DUR) via:

“(b) Use of predetermined standards. Retrospective DUR includes, but is not limited to, using predetermined standards to monitor for the following:

(1) Therapeutic appropriateness, that is, drug prescribing and dispensing that is in conformity with the predetermined standards.

*(2) **Overutilization and underutilization, as defined in Sec. 456.702.***

(3) Appropriate use of generic products, that is, use of such products in conformity with State product selection laws.

(4) Therapeutic duplication as described in Sec. 456.705(b)(1).

(5) Drug-disease contraindication as described in Sec. 456.705(b)(2).

(6) Drug-drug interaction as described in Sec. 456.705(b)(3).

(7) Incorrect drug dosage as described in Sec. 456.705(b)(4).

(8) Incorrect duration of drug treatment as described in Sec. 456.705(b)(5).

*(9) **Clinical abuse or misuse as described in Sec. 456.705(b)(7)**”*

The Department conducts retrospective reviews for this purpose every quarter. For each of the measures cited above an analysis is completed and the results of that analysis are reported to the Centers for Medicare and Medicaid Services (CMS) Region 10. These results are reported on forms CMS specifically created for reporting the results of the analysis on each of these measures, including overutilization and abuse and misuse.

The Department's Pharmacy Administrator has attended in-service trainings hosted by CMS to understand this requirement and assure the Department has in place activities that will support our compliance.

The Pharmacy Administrator uses the data to determine which drug or class will be the focus for each quarter. Predetermined standards are used along with a professional drug advisory committee to monitor all the measures cited above, including overutilization and abuse and misuse of any medication for that quarter. If “Abuse” and “Misuse” is identified in the process, the “suspected” abuser is referred to our internal resources of the Department: Office of Patient Review and Coordination (PRC), the Quality Management Team Unit (QMT), the Payment Review Program Unit (PRP) and the Office of Payment Review and Audit (OPRA).

The Department believed it had presented reports to the SAO which document our compliance with the CFR and will continue to work with the SAO to understand what additional documentation would meet their needs.

The Department has designated the Office of Payment Review and Audit (OPRA), part of our payment integrity division, as the Department's contact point for referrals to the Medicaid Fraud and Control Unit (MFCU). This was an internal protocol put into place in 2004 so there would be coordination and one source for this external body to interface with.

The CFR does not stipulate which drug class or specific drug(s) should be reviewed each quarter. It does not stipulate these reviews must be done looking at every physician's prescribing practices every quarter. Nor does it say the DUR must be conducted on every drug every quarter. The Department meets this requirement by looking at drug utilization by types of drugs or groups of drugs in a systematic way designed to identify the flags outlined above.

The Pharmacy Administrator contacted Madlyn Kruh, Pharmacist with CMS, in September 2009 to confirm that Washington Medicaid was in compliance with the federal requirements regarding retrospective and prospective DUR. Ms. Kruh sent the following email that verifies Washington's compliance:

“CMS finds that you are conducting your DUR program in accordance with Section 1927 (g) of the Social Security Act. You were acting appropriately to refer identified outliers to your internal audit and integrity section for further investigation. It is their responsibility to refer the case(s) on to MFCU if indeed fraud or abuse has been determined.

The DUR program is designed to educate physicians and pharmacists and patients on therapeutic appropriateness, over and under utilizations, therapeutic duplication, drug-disease contraindications, drug-drug interactions as well as clinical abuse and misuse.”

*“In addition, you are in compliance with 42 CFR Ch. IV sec. 456.714 which states:
§ 456.714 DUR/surveillance and utilization review relationship.*

(a) The retrospective DUR requirements in this subpart parallel a portion of the surveillance and utilization review (SUR) requirements in subpart A of this part and in part 455 of this chapter.

(b) A State agency may direct DUR staffs to limit review activities to those that focus on what constitutes appropriate and medically necessary care to avoid duplication of activities relating to fraud and abuse under the SUR program.”

This audit area continues to be one in which the auditors and DSHS disagree on the intent and focus of the CFR requirements. The Department’s focus is on the appropriateness of prescribing physicians drug selection; the auditors focus was on the usefulness of the utilization review in detecting fraud. The Department will continue to work with the auditors and jointly request CMS review of the Department’s efforts to comply with this CFR.

Auditor’s Remarks

We thank the Department for its response and commitment to continuing discussions on this issue.

Retrospective Drug Utilization Review (DUR) is a two-part system. The first component is the ongoing periodic examination of claims data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists and Medicaid recipients associated with specific drugs or groups of drugs. The purpose of this component of retrospective DUR is to reduce the frequency of misuse and overuse of Medicaid drug benefits.

The second component of retrospective DUR is an ongoing periodic examination of claims data and other records to assess the clinical quality of prescribing and dispensing of Medicaid-covered drugs. The purpose of this component of retrospective DUR is to reduce the frequency of therapeutic problems associated with the use of those drugs.

During our testing the Department was unable to supply us with any evidence showing that it performs ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, or gross overuse among physicians, pharmacists, and Medicaid recipients, or associated with specific drugs or groups of drugs.

The Department established procedures to perform the second component of retrospective DUR, believing this was sufficient. We re-affirm our finding, and look forward to continuing discussions with the Department and its grantor in order to achieve resolution.

Applicable Laws and Regulations

WAC 388-530-4050 Drug use and claims review states:

- (1) The department's drug use review (DUR) consists of:
 - (a) A prospective drug use review (Pro-DUR) that requires all pharmacy providers to:
 - (i) Obtain patient histories of allergies, idiosyncrasies, or chronic condition(s) which may relate to drug utilization;
 - (ii) Screen for potential drug therapy problems; and
 - (iii) Counsel the patient in accordance with existing state pharmacy laws and federal regulations.
 - (b) A retrospective drug use review (Retro-DUR), in which the department provides for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and individuals receiving benefits.

- (2) The department reviews a periodic sampling of claims to determine if drugs are appropriately dispensed and billed. If a review of the sample finds that a provider is inappropriately dispensing or billing for drugs, the department may implement corrective action that includes, but is not limited to:
 - (a) Educating the provider regarding the problem practice(s);
 - (b) Requiring the provider to maintain specific documentation in addition to the normal documentation requirements regarding the provider's dispensing or billing actions;
 - (c) Recouping the payment for the drug(s); and/or
 - (d) Terminating the provider's core provider agreement (CPA).

Title 42, Code of Federal Regulations, Section 456.703 states in part:

- (a) *General.* Except as provided in paragraphs (b) and (c) of this section, in order for FFP to be paid or made available under section 1903 of the Act for covered outpatient drugs, the State must have in operation, by not later than January 1, 1993, a DUR program consisting of prospective drug review, retrospective drug use review, and an educational program that meets the requirements of this subpart. The goal of the State's DUR program must be to ensure appropriate drug therapy, while permitting sufficient professional prerogatives to allow for individualized drug therapy.

Title 42, Code of Federal Regulations, Section 456.709 states:

- (a) *General.* The State plan must provide for a retrospective DUR program for ongoing periodic examination (no less frequently than quarterly) of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Medicaid recipients, or associated with specific drugs or groups of drugs. This examination must involve pattern analysis, using predetermined standards, of physician prescribing practices, drug use by individual patients and, where appropriate, dispensing practices of pharmacies. This program must be provided through the State's mechanized drug claims processing and information retrieval systems approved by CMS (that is, the Medicaid Management Information System (MMIS)) or an electronic drug claims processing system that is integrated with MMIS. States that do not have MMIS systems may use existing systems provided that the results of the examination of drug claims as described in this section are integrated within their existing system.
- (b) *Use of predetermined standards.* Retrospective DUR includes, but is not limited to, using predetermined standards to monitor for the following:
 - (1) Therapeutic appropriateness, that is, drug prescribing and dispensing that is in conformity with the predetermined standards.
 - (2) Overutilization and underutilization, as defined in Sec. 456.702.
 - (3) Appropriate use of generic products, that is, use of such products in conformity with State product selection laws.
 - (4) Therapeutic duplication as described in Sec. 456.705(b)(1).
 - (5) Drug-disease contraindication as described in Sec. 456.705(b)(2).
 - (6) Drug-drug interaction as described in Sec. 456.705(b)(3).
 - (7) Incorrect drug dosage as described in Sec. 456.705(b)(4).
 - (8) Incorrect duration of drug treatment as described in Sec. 456.705(b)(5).
 - (9) Clinical abuse or misuse as described in Sec. 456.705(b)(7).

Title 42 Code of Federal Regulations 455.2 states in part:

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Title 42 Code of Federal Regulations 455.14 Preliminary investigation states:

If the agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

Title 42 Code of Federal Regulations 455.15 Full investigation states in part:

If the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occurred in the Medicaid program, the agency must take the following action, as appropriate:

- (a) If a provider is suspected of fraud or abuse, the agency must—
 - (1) In States with a State Medicaid fraud control unit certified under subpart C of part 1002 of this title, refer the case to the unit under the terms of its agreement with the unit entered into under Sec. 1002.309 of this title; or
 - (2) In States with no certified Medicaid fraud control unit, or in cases where no referral to the State Medicaid fraud control unit is required under paragraph (a)(1) of this section, conduct a full investigation or refer the case to the appropriate law enforcement agency.
- (b) If there is reason to believe that a recipient has defrauded the Medicaid program, the agency must refer the case to an appropriate law enforcement agency.
- (c) If there is reason to believe that a recipient has abused the Medicaid program, the agency must conduct a full investigation of the abuse.

Title 42 Code of Federal Regulations 455.16 Resolution of full investigation states in part:

A full investigation must continue until—

- (a) Appropriate legal action is initiated;
- (b) The case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse; or
- (c) The matter is resolved between the agency and the provider or recipient. This resolution may include but is not limited to—
 - (1) Sending a warning letter to the provider or recipient, giving notice that continuation of the activity in question will result in further action;
 - (2) Suspending or terminating the provider from participation in the Medicaid program;
 - (3) Seeking recovery of payments made to the provider; or
 - (4) Imposing other sanctions provided under the State plan.

09-21 The Department of Social and Health Services, Aging and Disability Services Administration, Home and Community Based Services Division, does not have adequate internal controls to ensure Medicaid payments to in-home service providers are allowable and supported.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care Providers and Suppliers
93.778 Medical Assistance Program (Medicaid; Title XIX)
93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number: 5-0905WA5028, 5-0905W5048, 5-0905WAARRA
Applicable Compliance Component: Activities Allowed/Unallowed, Allowable Costs/Cost Principles
Questioned Cost Amount: \$1,030,677

Background

The Department of Social and Health Services, Aging and Disability Services Administration, administers the Home and Community Based Services program for the state. Through the program, the state pays for home and community-based services for Medicaid beneficiaries needing long-term care. These services, generally personal care and assistance, are provided by individuals or agencies often chosen by the Medicaid client, allowing the client to avoid institutionalization.

The Department determines the level of care needed and authorizes the number of service hours for that care, which forms the basis of the payment to the provider.

Depending on their financial resources, clients may be required to pay a portion of the costs of services. The Department pays the remainder up to the authorized amount. The service provider is required to record hours worked on a timesheet, to be signed by the client and the provider and retained for two years.

In our audit of program activities in fiscal year 2008, we reported a finding regarding the Department’s lack of adequate controls to ensure these payments are allowable and supported. In response to the finding the Department issued a Management Bulletin (H09-011) in March 2009 to Area Agencies on Aging and the Division of Developmental Disabilities to remind them that the law requires them to verify a sample of timesheets for allowability of services and charges.

The state paid more than \$450 million for these services during the fiscal year 2009.

Description of Condition

While the Department reminded case managers of the need to review timesheets, we found weaknesses in controls intended to ensure the payments are allowable and supported. Some case managers reviewed a sample of timesheets; others did not. We also found no comparison was done with the payment record in the Social Services Payment System (SSPS), which the Department uses to generate payments. During our audit, we did not receive any timesheets from 109 individual providers, representing 55 percent of the providers we selected. Some individual providers stated they were not aware of the need for timesheets or quit preparing timesheets since no case manager had asked for them.

We found no significant improvement in the weaknesses identified in the 2008 audit.

Cause of Condition

The Department stated that it considers the Medicaid client to be the “employer” of the service provider, and therefore it is the client’s responsibility to verify allowability and legitimacy of payments.

Effect of Condition

Although the client may be the employer of the service provider, Medicaid clients do not regularly receive detailed information on payment claims submitted to the Department. Therefore, a client would not be in a position to know if a provider submitted an incorrect or false claim.

To determine the effect of the control deficiencies, we asked the Department to obtain timesheets from 200 randomly selected providers for July 1, 2008 through March 31, 2009. We obtained detailed payment information from the Department and attempted to reconcile it to the timesheets to determine whether payments were legitimate and supported. Of the 200 providers reviewed, we found 62 provided adequate documentation. Of the remaining 138, we noted:

Description of issues	Number of issues	Related Expenditures
Payments were not supported with timesheets.	109	\$1,737,189.89
Providers provided incomplete timesheets and did not have all timesheets for the period requested.	*9	\$48,555.42
Timesheets were not totaled or incorrectly totaled.	*19	\$61,301.66
Timesheets with at least one month in which timesheet hours were less than the authorized hours on the Social Services Payment System.	*10	\$148,660.31
Timesheets showed no variances from month to month, and appear to be copies.	*4	\$65,647.23
Total	151	\$2,061,354.51

*: Issues possible in more than one category, which is why the number of exceptions is higher than the number of samples selected. Related questioned costs are not duplicated.

The Department paid a total of \$2,751,386.97 to these providers. We identified \$2,061,354.51 in payments that were not fully supported.

Approximately half of the questioned amount, or \$1,030,677, was paid with federal dollars.

Recommendation

We recommend the Department establish and follow internal controls to ensure:

- Payments made to individual providers are legitimate and supported.
- Individual providers maintain accurate timesheets to support payments they receive in keeping with federal requirements and state and department records retention schedules.

Department’s Response

The Department Concurrs with this Finding.

The Department concurs it does not have a process that provides Medicaid recipients with information on the number of hours billed to the Department by individual providers (IP). The Department is in the process of procuring a Provider Compensation System (PCS) that will improve the verification process. The PCS will be a sub-system of the Provider One, the new Medicaid Management Information System. However, it will be approximately two years before the system is implemented. Specifically, the new system will generate monthly

notices to all clients informing them how many hours were paid to the provider on their behalf during the previous month. The clients will be instructed to notify the Department if they notice a discrepancy in the hours provided versus the hours billed.

Until the new system is implemented, the Department will:

- Inform clients during annual assessments, and at the time of contracting with an individual provider, they are responsible for supervising their care provider. If a client is unable to do so, agency managed personal care may be available or the client and case manager can identify a representative who will monitor services. If a representative is not available, by policy (Chapter 3 of the Long Term Care Manual – Assessment Minimum Standards) the client receives more frequent contacts with the case manager who monitors the provision of services.
- Award letters and Planned Action Notices provide clients information on how to contact their case manager if there are concerns about service delivery. They can and should report problems with providers.
- Inform clients that as the employer they can terminate their provider. Also, the Department has the authority to terminate payment if there is a good faith belief that services are not being provided as authorized to a Medicaid client.

The Department provides the client a form titled - “Acknowledgement of My Responsibilities as the Employer of My Individual Providers” that explains the above bulleted information.

Additionally, the Social Service Payment System (SSPS) will not process payments in excess of hours authorized. A provider is, therefore, unable to claim and be reimbursed for hours that exceed those authorized by the case manager.

The Department will send a letter to all currently authorized IPs reminding them of their responsibilities as a contracted provider. Specifically, they will be reminded of their obligation to maintain records and respond to inquiries to produce documentation. The target date for this is April 2010.

The Department continues to maintain that state law assigns the responsibility for scheduling, tracking, and timekeeping to the client. In response to this finding, however, we have taken the following action during the past year:

- In March 2009, the Department issued a management bulletin to Area Agencies on Aging and the Division of Developmental Disabilities that addressed the statutory mandate to periodically review a sample of timesheets, verify the provision of services, and document the review of time sheets and the discussion of service verification in a Service Episode Record.
- In September 2009, the Department completed a revision of a written communication titled “Acknowledgement of My Responsibilities as the Employer of My Individual Providers”. On November 1, 2009, staff began reviewing this form with all clients who employ an individual provider. The form will be reviewed with all clients who employ an IP by October 31, 2010.

Auditor’s Remarks

We thank the Department for its cooperation and assistance throughout the audit. We look forward to reviewing the improvements the Department has implemented during our next audit.

Applicable Laws and Regulations:

Circular No. A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Subpart C, § .300 Auditee responsibilities. states in part:

The auditee shall:

- (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.

A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Compliance Supplement states in part:

General Audit Approach for Medicaid Payments To be allowable, Medicaid costs for medical services must be:

- (1) covered by the State plan and waivers;
- (2) for an allowable service rendered (including supported by medical records or other evidence indicating that the service was actually provided and consistent with the medical diagnosis);
- (3) properly coded; and
- (4) paid at the rate allowed by the State plan. Additionally, Medicaid costs must be net of applicable credits (e.g., insurance, recoveries from other third parties who are responsible for covering the Medicaid costs, and drug rebates), paid to eligible providers, and only provided on behalf of eligible individuals.

OMB Circular A-87: Cost Principles for State, Local and Indian Tribal Governments; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
 - a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
 - b. Be allocable to Federal awards under the provisions of 2 CFR part 225.
 - c. Be authorized or not prohibited under State or local laws or regulations.
 - d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
 - e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.
 - f. Be accorded consistent treatment. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Federal award as an indirect cost.
 - g. Except as otherwise provided for in 2 CFR part 225, be determined in accordance with generally accepted accounting principles.
 - h. Not be included as a cost or used to meet cost sharing or matching requirements of any other Federal award in either the current or a prior period, except as specifically provided by Federal law or regulation.
 - i. Be the net of all applicable credits.
 - j. Be adequately documented.

WAC 388-71-0515 states:

An individual provider or home care agency provider must:

- (1) Understand the client's plan of care that is signed by the client or legal representative and social worker/case manager, and translated or interpreted, as necessary, for the client and the provider;
- (2) Provide the services as outlined on the client's plan of care, as defined in WAC [388-106-0010](#);
- (3) Accommodate client's individual preferences and differences in providing care;
- (4) Contact the client's representative and case manager when there are changes which affect the personal care and other tasks listed on the plan of care;
- (5) Observe the client for change(s) in health, take appropriate action, and respond to emergencies;
- (6) Notify the case manager immediately when the client enters a hospital, or moves to another setting;

- (7) Notify the case manager immediately if the client dies;
- (8) Notify the department or AAA immediately when unable to staff/serve the client; and
- (9) Notify the department/AAA when the individual provider or home care agency will no longer provide services. Notification to the client/legal guardian must:
 - (a) Give at least two weeks' notice, and
 - (b) Be in writing.
- (10) Complete and keep accurate time sheets that are accessible to the social worker/case manager; and
- (11) Comply with all applicable laws and regulations.

Employment Reference Guide for Individual Providers (DSHS22-221(X) Page 8 states in part:

- § Make a check in all the personal care tasks listed on the form that you performed as defined in the Care Plan during that month.
- § After you have completed the form, have your employer review it for accuracy. If your employer agrees, he/she should sign their name under "CLIENT'S SIGNATURE".
- § Use your timesheet to fill out your SSPS Service Invoice accurately.
- § Keep one copy for your records (for two (2) years) and give one copy to your employer for his or her files.

RCW 74.39A.095 states:

- (1) In carrying out case management responsibilities established under RCW [74.39A.090](#) for consumers who are receiving services under the medicaid personal care, community options programs entry system or chore services program through an individual provider, each area agency on aging shall provide oversight of the care being provided to consumers receiving services under this section to the extent of available funding. Case management responsibilities incorporate this oversight, and include, but are not limited to:
 - (a) Verification that any individual provider who has not been referred to a consumer by the authority established under chapter 3, Laws of 2002 has met any training requirements established by the department;
 - (b) Verification of a sample of worker time sheets;
 - (c) Monitoring the consumer's plan of care to verify that it adequately meets the needs of the consumer, through activities such as home visits, telephone contacts, and responses to information received by the area agency on aging indicating that a consumer may be experiencing problems relating to his or her home care;
 - (d) Reassessment and reauthorization of services;
 - (e) Monitoring of individual provider performance. If, in the course of its case management activities, the area agency on aging identifies concerns regarding the care being provided by an individual provider who was referred by the authority, the area agency on aging must notify the authority regarding its concerns; and
 - (f) Conducting criminal background checks or verifying that criminal background checks have been conducted for any individual provider who has not been referred to a consumer by the authority.
- (2) The area agency on aging case manager shall work with each consumer to develop a plan of care under this section that identifies and ensures coordination of health and long-term care services that meet the consumer's needs. In developing the plan, they shall utilize, and modify as needed, any comprehensive community service plan developed by the department as provided in RCW [74.39A.040](#). The plan of care shall include, at a minimum:
 - (a) The name and telephone number of the consumer's area agency on aging case manager, and a statement as to how the case manager can be contacted about any concerns related to the consumer's well-being or the adequacy of care provided;
 - (b) The name and telephone numbers of the consumer's primary health care provider, and other health or long-term care providers with whom the consumer has frequent contacts.
 - (c) A clear description of the roles and responsibilities of the area agency on aging case manager and the consumer receiving services under this section;
 - (d) The duties and tasks to be performed by the area agency on aging case manager and the consumer receiving services under this section;
 - (e) The type of in-home services authorized, and the number of hours of services to be provided;

- (f) The terms of compensation of the individual provider;
- (g) A statement by the individual provider that he or she has the ability and willingness to carry out his or her responsibilities relative to the plan of care; and
- (h)
 - (i) Except as provided in (h)(ii) of this subsection, a clear statement indicating that a consumer receiving services under this section has the right to waive any of the case management services offered by the area agency on aging under this section, and a clear indication of whether the consumer has, in fact, waived any of these services.
 - (ii) The consumer's right to waive case management services does not include the right to waive reassessment or reauthorization of services, or verification that services are being provided in accordance with the plan of care.
- (3) Each area agency on aging shall retain a record of each waiver of services included in a plan of care under this section.
- (4) Each consumer has the right to direct and participate in the development of their plan of care to the maximum practicable extent of their abilities and desires, and to be provided with the time and support necessary to facilitate that participation.
- (5) A copy of the plan of care must be distributed to the consumer's primary care provider, individual provider, and other relevant providers with whom the consumer has frequent contact, as authorized by the consumer.
- (6) The consumer's plan of care shall be an attachment to the contract between the department, or their designee, and the individual provider.
- (7) If the department or area agency on aging case manager finds that an individual provider's inadequate performance or inability to deliver quality care is jeopardizing the health, safety, or well-being of a consumer receiving service under this section, the department or the area agency on aging may take action to terminate the contract between the department and the individual provider. If the department or the area agency on aging has a reasonable, good faith belief that the health, safety, or well-being of a consumer is in imminent jeopardy, the department or area agency on aging may summarily suspend the contract pending a fair hearing. The consumer may request a fair hearing to contest the planned action of the case manager, as provided in chapter [34.05](#) RCW. When the department or area agency on aging terminates or summarily suspends a contract under this subsection, it must provide oral and written notice of the action taken to the authority. The department may by rule adopt guidelines for implementing this subsection.
- (8) The department or area agency on aging may reject a request by a consumer receiving services under this section to have a family member or other person serve as his or her individual provider if the case manager has a reasonable, good faith belief that the family member or other person will be unable to appropriately meet the care needs of the consumer. The consumer may request a fair hearing to contest the decision of the case manager, as provided in chapter [34.05](#) RCW. The department may by rule adopt guidelines for implementing this subsection.

09-22 The Department of Social and Health Services, Health and Recovery Services Administration’s internal controls are insufficient to ensure payment rates to its Healthy Options managed care providers are based on accurate data.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care Providers and Suppliers
93.778 Medical Assistance Program (Medicaid; Title XIX)
93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number: 5-0905WA5028, 5-0905W5048, 5-0905WAARRA
Applicable Compliance Component: Special Tests and Provisions: Managed Care
Questioned Cost Amount: None

Background

Managed care providers receive a uniform, pre-determined, per-patient monthly rate regardless of the number of times they see the patient each month and regardless of services provided, as long as the services are covered under the plan. Although these providers are not paid based on the types of procedures, they still must report that information to the Health and Recovery Services Administration. This data is to include demographic, diagnostic and geographic information, as well as actual costs on a summary level.

The Administration contracts with an actuary to analyze the data from managed care providers and to develop actuarially sound capitation, or per-person, rates. From this information, the Administration determines a rate for each managed care plan. In general, the plans including more seriously ill people will receive higher rates and the plans including healthier people will be given lower rates.

In fiscal years 2003 through 2008, we reported concerns regarding the Administration’s lack of review of the accuracy of data received from providers that is used to determine managed care program rates.

From July 2008 through June 2009, the state paid more than \$1.3 billion to managed care providers. This is an increase of \$129 million over the previous year. Since October 1 2008, these payments are eligible for increased Federal Medical Assistance Percentage (FMAP) due to the American Recovery and Reinvestment Act of 2009. Federal dollars now can be used to pay for 60 percent, rather than 50 percent, of program costs.

Description of Condition

We have reported this condition since 2006. During our current audit, we found no change in the conditions. The Administration continues to rely on providers to accurately report the data used to determine the rates and does not verify its accuracy. Although the Administration has an actuarially sound process for calculating rates, if the underlying data used is inaccurate or incomplete, the results will be inaccurate.

Cause of Condition

The Department believes its calculation method complies with federal requirements. The Department also stated it does not have the expertise to review the information the providers submit to the actuary for accuracy and completeness.

Effect of Condition

When the accuracy of data used to establish rates cannot be reasonably assumed to be correct, the risk of paying inflated rates to managed care providers is increased.

Recommendation

We recommend the Department establish and follow controls to provide reasonable assurance that the data used in rate-setting is accurate and complete.

Department's Response

The Department continues to not concur with this audit finding.

There are sufficient controls in-place to assure that managed care rates are set based on the verified managed care organizations (MCO) actual costs of care. Actuarially certified, proprietary cost information is submitted directly to the Department's actuary. The actuary verifies the information submitted by comparing it to audited financial statements submitted to the Office of the Insurance Commissioner, and encounter data submitted to the Department. The actuary also does analysis of prior years, compares MCOs to each other and resolves outliers that arise from its analyses with the MCOs.

In addition, the MCOs each have compliant fraud and abuse controls to prevent provider fraud. These controls provide reasonable assurance that the data used in rate-setting is accurate and complete. This assertion is supported by the fact that the Department has had no findings regarding rate setting in two Centers for Medicare and Medicaid Services (CMS) reviews and has had its rates consistently approved by CMS with their full understanding of our rate setting methodology.

Auditor's Concluding Remarks

We thank the Department for its response, and will follow up during our next audit.

Applicable Laws and Regulations

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 300, states in part:

The auditee shall:

- (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.

Title 42, Code of Federal Regulations, Section 456.3 states, in part:

The Medicaid agency must implement a statewide surveillance and utilization control program that –

- b. Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments

Title 42 CFR 438.6 Contract requirements, states in parts:

(c) *Payments under risk contracts* —

- (1) *Terminology*. As used in this paragraph, the following terms have the indicated meanings:

(i) *Actuarially sound capitation rates* means capitation rates that—

- (A) Have been developed in accordance with generally accepted actuarial principles and practices;
- (B) Are appropriate for the populations to be covered, and the services to be furnished under the contract; and
- (C) Have been certified, as meeting the requirements of this paragraph (c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

- (3) *Requirements for actuarially sound rates*. In setting actuarially sound capitation rates, the State must apply the following elements, or explain why they are not applicable:

- (i) Base utilization and cost data that are derived from the Medicaid population, or if not, are adjusted to make them comparable to the Medicaid population.
- (4) *Documentation.* The State must provide the following documentation:
- (i) The actuarial certification of the capitation rates.
 - (ii) An assurance (in accordance with paragraph (c)(3) of this section) that all payment rates are—
 - (A) Based only upon services covered under the State plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration).
 - (B) Provided under the contract to Medicaid-eligible individuals.

09-23 The Department of Social and Health Services is not complying with staffing requirements in its Medicaid Eligibility Quality Control project agreement.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
 93.775 State Medicaid Fraud Control Units
 93.776 Hurricane Katrina Relief
 93.777 State Survey and Certification of Health Care Providers and Suppliers
 93.778 Medical Assistance Program (Medicaid; Title XIX)
 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number: 5-0905WA5028, 5-0905W5048, 5-0905WAARRA
Applicable Compliance Component: Eligibility
Questioned Cost Amount: None

Background

The Medicaid program serves more than 1 million individuals in the state annually. In order to simplify and streamline its monitoring of states’ eligibility determinations, the federal Centers for Medicare and Medicaid Services (CMS) uses the Medicaid Eligibility Quality Control (MEQC) System. This system allows states to review a sample of Medicaid eligibility determinations to establish an error rate. If the error rate is over the limit the federal grantor identifies as acceptable, the state claims may be disallowed. The integrity of the MEQC process is critical due of the number of clients involved and the associated costs: even a small change in the error rate could have significant impact on the state’s federal funding.

In October of 1994, Washington was one of more than 30 states that entered into an agreement with CMS to run an MEQC pilot program. The pilot was intended to allow states to develop alternative ways to effectively identify and reduce incorrect payments. As long as the pilot program is in effect, the state’s error rate is frozen at the rate identified through its last normal MEQC.

When the state entered into the pilot project agreement with the U.S. Department of Health and Human Services (HHS), it agreed to maintain the level of staffing that had been devoted to the traditional quality control reviews. This level was specified as a minimum of 8.5 full-time employees, distributed throughout the state’s Quality Control units.

For fiscal year 2009, the state spent \$6.8 billion in Medicaid money; approximately \$4.1 billion was federal dollars.

Description of Condition

During our audit we found the Department has reduced the total number of full-time employees committed to MEQC to four.

Year	1994-1997	1997-2003	2003-2007	2007	2008	2009
FTE	8.5	7.5	6.5	5.5	5	4

We recommended the Department contact CMS and get approval for the reduction. The Department stated that it contacted CMS but CMS would not give the Department an approval in writing.

Cause of Condition

When asked, staff involved in the MEQC indicated it did not know why the full time employees dedicated to the program had been reduced.

Effect of Condition

The reduction in staffing levels affects the scope of the pilot project that is designed to ensure program integrity or improve program administration. Controls over eligibility determination could be weakened and the risk of ineligible individuals receiving Medicaid benefits could be increased. Non-compliance with the terms of the agreement could also affect the Department's ability to continue in the pilot and the grantor's acceptance of the current error rate.

Recommendation

We recommend the Department comply with the agreement or receive written approval for the reduction in staff dedicated to the MEQC from the federal grantor.

Department's Response

The Department partially concurs with this finding.

While it is true the number of FTEs dedicated to Medicaid Eligibility Quality Control (MEQC) has been reduced, in August 2009, the Department submitted and received approval for a one-year extension of the MEQC Pilot Project which included the reduced staffing. The request, attached in its entirety, included the following:

"... We request your approval of an extension of the MEQC Pilot Project for the period.....with dedicated staffing at 5 FTEs: 1.0 Program Manager, 1.0 Administrative Support, 3.0 Quality Control Specialists..."

With this request and the October 2009 approval of the proposal as submitted by the Department of Health and Human Services, the Department has already accomplished the recommendation, approval attached in its entirety.

Auditor's Remarks

We appreciate the action taken by the Department to correct the condition identified. We will review this area during our next audit.

Applicable Laws and Regulations

The initial acceptance of Washington State's pilot Medicaid Eligibility Quality Control process agreement states in part:

Our plan is to decentralize the pilot and have five QC reviewers stationed around the state in five of our QC units. Besides these five reviewers, the supervision and clerical support will be provided from these locations. One-fifth of the supervisors' time and clerical workers' time will be devoted to these positions. In addition to this total of seven FTEs, we will be assigning a headquarters staff person to oversee this project 50 percent of the time. Also, a research analyst will be assigned full time. In addition, administrative time of the QC Director will occur, particularly in the developmental states. We will also have a data compiler available for when project reports are being written. Therefore, a minimum of 8.5 FTEs will be devoted to the project which clearly meets staffing levels currently devoted to the medical program.

Title 42, code of Federal Regulation, Section 431 states in part:

§ 431.810 Basic elements of the Medicaid eligibility quality control (MEQC) program.

- (a) General requirements. The agency must operate the MEQC program in accordance with this section and §§431.812 through 431.822 and other instructions established by CMS.
- (b) Review requirements. The agency must conduct MEQC reviews in accordance with the requirements specified in §431.812 and other instructions established by CMS.
- (c) Sampling requirements. The agency must conduct MEQC sampling in accordance with the requirements specified in §431.814 and other instructions established by CMS.

§ 431.820 Corrective action under the MEQC program.

The agency must—

- (a) Take action to correct any active or negative case action errors found in the sample cases;
- (b) Take administrative action to prevent or reduce the incidence of those errors; and
- (c) By September 15 each year, submit to CMS a report on its error rate analysis and a corrective action plan based on that analysis. The agency must submit revisions to the plan within 60 days of identification of additional error-prone areas, other significant changes in the error rate (that is, changes that the State experiences that increase or decrease its error rate and necessitate immediate corrective action or discontinuance of corrective actions that effectively control the cause of the error rate change), or changes in planned corrective action.

09-24 The Department of Social and Health Services, Health and Recovery Services Administration, does not have a system in place to adequately compensate for an inherent control weakness that is susceptible to errors and abuse.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care
Providers and Suppliers
93.778 Medical Assistance Program
93.778 Medical Assistance Program (Medicaid; Title XIX)
– American Recovery and Reinvestment Act
(ARRA)
Federal Award Number: 5-0905WA5028, 5-0905W5048, 5-0905WAARRA
Applicable Compliance Component: Activities Allowed/Unallowed, Allowable Costs/Cost
Principles
Questioned Cost Amount: None

Background

Medicaid is the “payer of last resort”, meaning that other payment sources should be identified and used prior to submitting claims to Medicaid. Third-party liability refers to the legal obligation of third-party resources, usually insurance companies, to pay medical and pharmaceutical claims of Medicaid recipients prior to Medicaid coverage. The function of third-party liability within the Medicaid program is to ensure non-Medicaid resources are the primary source of payment. Federal regulations require states to have processes to identify third parties liable for payment of services before Medicaid dollars are used.

Pharmacies submit claims for Medicaid client prescriptions through an electronic point-of-sale system, which processes requests for payment through a series of criteria within the system, or edits. Claims are paid if they successfully pass all edits.

When pharmacies submit claims for payment to Medicaid, they must document third-party payers that may be liable for paying. If a provider submits a claim on behalf of a client who has other insurance without accurately entering the third-party resource, the point-of-sale system will deny the claim. However, the system edits intended to identify and deny these claims can be rendered inoperative by use of manual override codes. The override codes, part of the National Council for Prescription Drugs Programs electronic claims submission standard, are recognized nationally as electronic claims processing standards. The override codes were established for uses such as processing payment for a drug the client’s insurance does not cover, but which is covered by Medicaid.

In our audits for fiscal years 2006 through 2008, we reported a lack of adequate controls over use of other coverage codes. The accuracy of information entered into the system depends on the pharmacy. The pharmacy can enter either the accurate third-party payer information or override codes to bypass the system that would deny payment on the claim should the information be inaccurate.

Due to this significant, inherent control weakness, claims for pharmaceutical payments are susceptible to errors or abuse. Claims that should have been paid in whole or in part by third parties could be paid by the Medicaid program. To compensate for this, the Department established a post-payment audit program to identify and recover payments made to providers who inappropriately billed Medicaid.

The Department paid more than \$475 million to pharmacies for services to Medicaid clients in fiscal year 2009. Of that, more than \$20 million was paid for claims using other coverage code 2,3,4,7 and 8 excluding Medicare Part D.

Description of Condition

We reviewed the Department’s post-payment audit program to determine if it is effective in identifying overpayments and recovering overpayments. We reviewed the Department’s third-party liability audit selection procedures, risk assessment and post-payment audit coverage.

We found the Department has a good understanding of where overpayment risks occur and what they are. Quarterly, the Department pulls data from its Medicaid claims payment system (MMIS) and the point-of-sale system and analyzes claims in which override codes were used. The table below shows total claims paid using other coverage code 2,3,4,7 and 8 excluding Part D.

	2007	2008	2009	Total
Total Pharmacy Claims Paid	\$18,539,287.40	\$19,560,496.82	\$20,627,840.66	\$58,727,624.88
Total Pharmacy Medicaid Claims Audited	\$996,534.61	\$1,333,714.07	\$507,781.44	\$2,838,030.12
% of Claims Audited	5.38%	6.82%	2.46%	4.83%

Other Coverage Code 2: Other coverage exists, payment collected
 Other Coverage Code 3&4: Other coverage exists, claim not covered
 Other Coverage Code 7: Other coverage exists, not in effect at time of service
 Other Coverage Code 8: Contracted copayments

While we found the process to be effective, the amount of coverage is insufficient to address the risk of overpayments. The Department could not demonstrate a correlation between the amount of potential overpayments and the resources it devotes to identifying and recovering them. Only 2.46 percent of the claims processed using other coverage codes in fiscal year 2009 were audited.

As shown in the table below, a significant portion of the payments audited by the Department are found to be inappropriate, and are subsequently recovered. These recoveries include state and federal money.

	2007	2008	2009	Totals
Total audits completed	10	12	15	37
Total Pharmacy Medicaid Claims Audited	\$996,534.61	\$1,333,714.07	\$507,781.44	\$2,838,030.12
Overpayments Identified	\$490,451.19	\$624,164.18	\$ 333,287.57	\$1,447,902.94
Overpayments Recovered as of 11/4/2009	\$485,154.10	\$550,848.58	\$ 241,302.24	\$1,277,304.92
Overpayment Percentage	49.22%	46.80%	65.64%	51.02%
Recovery Percentage	48.68%	41.30%	47.52%	45.01%
Collection Percentage	98.92%	88.25%	72.40%	88.22%

Cause of Condition

The Department stated it has compensating controls in place to provide reasonable assurance that improper payments will be recovered through its post-payment audit process.

The Department has not performed an analysis to determine what would be an appropriate amount of post-payment audit coverage to maximize recovery of overpayment.

Effect of Condition

Inaccurate third-party liability coverage information can be entered into the point-of-sale system causing Medicaid dollars to be spent on pharmacy services that should have been paid by third parties. Due to the lack of risk analysis and adequate post-payment audits, the Department cannot reasonably assure improper payments will be identified and recovered.

The Department's own audit work shows that \$1.4 million, or 51 percent of the amount audited over the past three years was improperly billed to Medicaid. The Department recovered approximately \$1.2 million from pharmacies as of November 4, 2009. Approximately half of the funds recovered are federal, and half are state.

Recommendation

We recommend the Department:

- Strengthen controls over entry of claims into the payment system to ensure third-party payers are properly billed before Medicaid is billed, as required by federal regulations.
- Perform on-going risk analysis and assessment to determine the appropriate level of post-payment audit coverage for third-party liability claims to ensure improper payments will be identified and recovered.

Department's Response

The Department partially concurs with this finding.

The Department agrees with the recommendation to strengthen controls over the entry of claims into the Pharmacy Point of Sale (POS) and will continue to explore and pursue these changes via the established system Change Control process. Some controls have already been identified that have the potential to provide enhanced information to pharmacies via POS. These changes are dependent upon additional information in the Coordination of Benefits (COB) portion of ProviderOne and will be further explored as soon as ProviderOne is implemented. The Department is also exploring the feasibility of other cost-avoidance methods including contracting with vendors for some COB eligibility reviews at the point of adjudication.

The Department disagrees with the statement in the "Effect of Condition - Due to the lack of risk analysis and adequate post-payment audits, the Department cannot reasonably assure improper payments will be identified and recovered". This statement contradicts the State Auditor's State Government Performance Review Opportunities for Washington dated December 2009. In the Government Reform section of that report, "Medicaid Pharmacy Overpayments" SAO found that "the Department uses a risk assessment to prioritize and target pharmacy claims with a high potential for a return of investment." The report further states that the risk assessment process is effective in identifying high-risk payments, but current Department resources are limited and that an opportunity for funding additional auditors was identified.

Auditor's Remarks

We thank the Department for its response, and will review this area during our next audit.

Applicable Laws and Regulations

OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations, Section 300, states in part:

The auditee shall:

- (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.

42CFR433.139 (b) (1) states:

If the agency has established the probable existence of third party liability at the time the claim is filed, the agency must reject the claim and return it to the provider for a determination of the amount of liability. The establishment of third party liability takes place when the agency receives confirmation from the provider or a third party resource indicating the extent of third party liability. When the amount of liability is determined, the agency must then pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment.

42CFR 433.140 (a) stipulates the following regarding a state's claim for federal financial participation:

- (a) FFP is not available in Medicaid payments if—
 - (1) The agency failed to fulfill the requirements of §§433.138 and 433.139 with regard to establishing liability and seeking reimbursement from a third party;
 - (2) The agency received reimbursement from a liable third party; or
 - (3) A private insurer would have been obligated to pay for the service except that its insurance contract limits or excludes payments if the individual is eligible for Medicaid.
- (b) FFP is available at the 50 percent rate for the agency's expenditures in carrying out the requirements of this subpart.

42CFR 433.139 states in part:

- (b) *Probable liability is established at the time claim is filed.* Except as provided in paragraph (e) of this section—
 - (1) If the agency has established the probable existence of third party liability at the time the claim is filed, the agency must reject the claim and return it to the provider for a determination of the amount of liability. The establishment of third party liability takes place when the agency receives confirmation from the provider or a third party resource indicating the extent of third party liability. When the amount of liability is determined, the agency must then pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment.

WAC 388-501-0200 states:

- (1) MAA requires a provider to seek timely reimbursement from a third party when a client has available third-party resources, except as described under subsections (2) and (3) of this section.
- (2) MAA pays for medical services and seeks reimbursement from the liable third party when the claim is for any of the following:
 - (a) Prenatal care;
 - (b) Labor, delivery, and postpartum care (except inpatient hospital costs) for a pregnant woman; or
 - (c) Preventive pediatric services as covered under the EPSDT program.
- (3) MAA pays for medical services and seeks reimbursement from any liable third party when both of the following apply:
 - (a) The provider submits to MAA documentation of billing the third party and the provider has not received payment after thirty days from the date of services; and
 - (b) The claim is for a covered service provided to a client on whose behalf the office of support enforcement is enforcing an absent parent to pay support. For the purpose of this section, "is enforcing" means the absent parent either:
 - (i) Is not complying with an existing court order; or
 - (ii) Received payment directly from the third party and did not pay for the medical services.
- (4) The provider may not bill MAA or the client for a covered service when a third party pays a provider the same amount as or more than the MAA rate.
- (5) When the provider receives payment from the third party after receiving reimbursement from MAA, the provider must refund to MAA the amount of the:
 - (a) Third-party payment when the payment is less than MAA's maximum allowable rate; or
 - (b) MAA payment when the third-party payment is equal to or greater than MAA's maximum allowable rate.
- (6) MAA is not responsible to pay for medical services when the third-party benefits are available to pay for the client's medical services at the time the provider bills MAA, except as described under subsections (2) and (3) of this section.
- (7) The client is liable for charges for covered medical services that would be paid by the third party payment when the client either:
 - (a) Receives direct third-party reimbursement for such services; or
 - (b) Fails to execute legal signatures on insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered. See WAC 388-505-0540 for assignment of rights.

- (8) MAA considers an adoptive family to be a third-party resource for the medical expenses of the birth mother and child only when there is a written contract between the adopting family and either the birth mother, the attorney, the provider, or the adoption service. The contract must specify that the adopting family will pay for the medical care associated with the pregnancy.
- (9) A provider cannot refuse to furnish covered services to a client because of a third party's potential liability for the services.
- (10) For third-party liability on personal injury litigation claims, MAA is responsible for providing medical services as described under WAC 388-501-0100.

09-25 The Department of Social and Health Services, Health and Recovery Services Administration, internal controls are inadequate to ensure errors identified by the Medical Eligibility Quality Control Unit are reviewed adequately and in a timely manner.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care Providers and Suppliers
93.778 Medical Assistance Program (Medicaid; Title XIX)
93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number: 5-0905WA5028, 5-0905W5048, 5-0905WAARRA
Applicable Compliance Component: Eligibility
Questioned Cost Amount: None

Background

The state is required to operate a Medicaid Eligibility Quality Control System (MEQC) to identify and reduce errors in Medicaid eligibility determinations and claims processing. The state has operated a MEQC pilot program since October 1994. These pilot projects are intended to allow states to develop ways to effectively identify and reduce erroneous payments, increase operational efficiencies, streamline service deliveries and to study and improve program operations.

Once the MEQC has identified errors in eligibility or claims, the Department is required to correct them, and recover Medicaid funds paid on ineligible claims. The Department also is required to take administrative action to prevent and reduce errors, and to submit to its federal grantor, the Centers for Medicare and Medicaid Services, a report of its error analysis and a corrective action plan.

In our audit of state fiscal year 2008, we reported a finding regarding the Department’s lack of adequate controls to ensure errors identified by the MEQC unit are adequately reviewed.

The state had Medicaid expenditures of approximately \$6.8 billion in fiscal year 2009, of which approximately \$4.1 billion was federal dollars.

Description of Condition

During our audit we selected two reviews; one has more complex income eligibility requirements and the other includes social security number alerts that had been mismanaged. We reviewed these two MEQC reviews to determine if the Department made an appropriate response to errors identified by MEQC.

We found a lack of monitoring to ensure adequate corrective action is being taken. We selected a sample of 21 cases with errors from the first review, and 20 cases with errors from the second review. We found no indication of follow up in six cases from the first review and five cases from the second review.

Cause of Condition

Department headquarters did not have effective monitoring to make certain all field offices were reviewing issues reported by MEQC. They believed that since the instances had been communicated to the field offices the expected reviews would take place without further monitoring.

The Department stated it has new requirements to monitor and track the review of MEQC issues.

Effect of Condition

Inadequate follow up on errors identified by MEQC increases the risk of ineligible individuals receiving Medicaid benefits.

Recommendation

We recommend the Department establish internal controls and monitoring to ensure errors identified by MEQC are reviewed appropriately and in a timely manner.

Department's Response

The Department concurs with this finding.

As a result, the Department has implemented procedures to ensure that MEQC audits are corrected by field offices in a timely manner by designating a program manager to process and monitor corrective actions for MEQC audits. The process is as follows:

- *The MEQC program manager will notify: HRSA's audit liaison and HRSA's regional representative of all MEQC audits;*
- *The HRSA audit liaison will notify the regional representative within a specified time when an audit is outstanding and inform the representative the field must take corrective action on the audit within a specified period of time; and*
- *All corrective actions will be monitored by the HRSA audit liaison and reported back to the MEQC program manager on a monthly basis until corrective actions are completed.*

Auditor's Remarks

We appreciate the cooperation and assistance provided by the Department throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

Title 42, code of Federal Regulation, Section 431 states in part:

§ 431.810 Basic elements of the Medicaid eligibility quality control (MEQC) program.

- (a) General requirements. The agency must operate the MEQC program in accordance with this section and §§431.812 through 431.822 and other instructions established by CMS.
- (b) Review requirements. The agency must conduct MEQC reviews in accordance with the requirements specified in §431.812 and other instructions established by CMS.
- (c) Sampling requirements. The agency must conduct MEQC sampling in accordance with the requirements specified in §431.814 and other instructions established by CMS.

§ 431.818 Access to records: MEQC program.

- (a) The agency, upon written request, must mail to the HHS staff all records, including complete local agency eligibility case files or legible copies and all other documents pertaining to its MEQC reviews to which the State has access, including information available under part 435, subpart I, of this chapter.
- (b) The agency must mail requested records within 10 working days of receipt of a request, unless the State has an alternate method of submitting these records that is approved by CMS or has received, on an as-needed basis, approval from CMS to extend this timeframe by 3 additional working days to allow for exceptional circumstances.

§ 431.820 Corrective action under the MEQC program.

The agency must—

- (a) Take action to correct any active or negative case action errors found in the sample cases;
- (b) Take administrative action to prevent or reduce the incidence of those errors; and

- (c) By September 15 each year, submit to CMS a report on its error rate analysis and a corrective action plan based on that analysis. The agency must submit revisions to the plan within 60 days of identification of additional error-prone areas, other significant changes in the error rate (that is, changes that the State experiences that increase or decrease its error rate and necessitate immediate corrective action or discontinuance of corrective actions that effectively control the cause of the error rate change), or changes in planned corrective action.

09-26 The Department of Social and Health Services, Aging and Disability Services Administration, does not adequately monitor subrecipients to ensure Medicaid expenditures are allowable and supported.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-0905WA5028, 5-0905W5048, 5-0905WAARRA
Applicable Compliance Component:	Subrecipient Monitoring
Questioned Cost Amount:	None

Background

The Department of Social and Health Services, Aging and Disability Services Administration, administers Medicaid programs and pass-through funding to Area Agencies on Aging to coordinate health care management for elderly and disabled people. Medicaid is the major source of public funding for long-term care services and supports providers in in-home and community settings administered by the agencies.

The Department, as the pass-through agency, is responsible for ensuring federal grant information and compliance requirements are communicated to the agencies. It is also responsible for monitoring their activities to ensure compliance with financial and program requirements.

The Department initially determines both the financial and functional eligibility of clients for services, authorizing hours and types of services that are paid through the Social Services Payment System (SSPS). After the initial determination, assessments for continuing eligibility are performed on an annual or as-needed basis through case managers at the agencies. The Department determines financial eligibility.

Because the on-going allowability and adequacy of services is determined by case managers at the agencies, on-site monitoring by the Department is critical to ensure expenditures are allowable and supported and quality services are being provided to the client in accordance with federal and state laws and regulations.

During fiscal year 2009 the Department spent more than \$425 million for the 13 Area Agencies on Aging operations and services they are administering.

Since October 2008, Medicaid payments are eligible for increased Federal Medical Assistance Percentages due to the American Recovery and Reinvestment Act of 2009 (ARRA). This means the state receives more funding for eligible Medicaid expenses – from approximately 50 percent previously to now over 60 percent.

Description of Condition

We found the Department has policies and procedures related to its monitoring the agencies. It has a schedule of on-site financial and contract monitoring for them, but has not followed the schedule or performed on-site monitoring since 2005.

Cause of Condition

The Department states it has used all available resources for other purposes, and had no resources to perform on-site monitoring at Area Agencies on Aging.

Effect of Condition

By not performing adequate on-site monitoring of subrecipients, the Department cannot ensure expenditures are allowable and supported and programs are administered in accordance with federal and state laws and regulations.

Recommendation

We recommend the Department follow its planned schedule of on-site fiscal and contract monitoring of Area Agencies on Aging.

Department's Response

During the timeframe of this audit, department resources were deployed to operate and train one area agency on aging as it received certification and became operational, as well as to resolve findings from prior years' monitoring. Due to this workload, subrecipient monitoring, which was scheduled to begin in 2009, was delayed until 2010.

Approximately 98 percent of the referenced \$425 million for the 13 Area Agencies on Aging is for client services and the administration of those services. All Area Agencies on Aging received in-depth monitoring of Medicaid case management, nursing services activities, and client services between May 2008 and December 2009. The monitoring is performed by a quality assurance unit within ADSA.

We are scheduled to begin fiscal and contract monitoring on the funding subject to OMB circular A-133 in SFY 2010.

Auditor's Remarks

We appreciate the cooperation and assistance provided by the Department throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 300, states in part:

The auditee shall:

- (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.

Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 400, states in part:

(d) **Pass-through entity responsibilities.** A pass-through entity shall perform the following for the Federal awards it makes:

- (1) Identify Federal awards made by informing each subrecipient of CFDA title and number, award name and number, award year, if the award is R&D, and name of Federal agency. When some of this information is not available, the pass-through entity shall provide the best information available to describe the Federal award.
- (2) Advise subrecipients of requirements imposed on them by Federal laws, regulations, and the provisions of contracts or grant agreements as well as any supplemental requirements imposed by the pass-through entity.
- (3) Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.

- (4) Ensure that subrecipients expending \$300,000 (*\$500,000 for fiscal years ending after December 31, 2003*) or more in Federal awards during the subrecipient's fiscal year have met the audit requirements of this part for that fiscal year.
- (5) Issue a management decision on audit findings within six months after receipt of the subrecipient's audit report and ensure that the subrecipient takes appropriate and timely corrective action.
- (6) Consider whether subrecipient audits necessitate adjustment of the pass-through entity's own records.
- (7) Require each subrecipient to permit the pass-through entity and auditors to have access to the records and financial statements as necessary for the pass-through entity to comply with this part.

09-27 The Department of Social and Health Services did not ensure Medicaid services provided to undocumented aliens were allowable under its Alien Emergency Medical program.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-0905WA5028, 5-0905W5048, 5-0905WAARRA
Applicable Compliance Component:	Activities Allowed or Unallowed
Questioned Cost Amount:	Non-ARRA: \$ 181,841.59 ARRA : \$ 26,297.27

Background

Medicaid is a jointly funded state and federal partnership providing health coverage for selected categories of people with low incomes who might otherwise go without medical care. The state Medicaid program spent more than \$6.8 billion during fiscal year 2009. Since October 2008, Medicaid payments are eligible for increased Federal Medical Assistance Percentages due to the American Recovery and Reinvestment Act of 2009. What previously would be federally funded at approximately 50 percent is now eligible for funding at over 60 percent.

Under federal law, all U.S. citizens and certain legal immigrants who meet Medicaid’s financial and non-financial eligibility criteria are entitled to Medicaid. Undocumented aliens are not eligible to receive general Medicaid benefits. However, they may be eligible for care and services necessary in an emergency medical situation that is not related to an organ transplant.

Federal law requires the state to have an Alien Emergency Medical (AEM) program for these emergency situations for undocumented aliens who meet all Medicaid program requirements with the exception of immigration status. This program covers low-income families, children and adults who are aged, blind, or disabled.

The program defines emergency medical conditions as the sudden onset of a medical condition (including labor and delivery) whose symptoms are acute and severe (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Description of Condition

In our current audit, we reviewed the validity of Social Security numbers for people who received Medicaid benefits. We identified and reviewed services provided to 40 undocumented aliens totaling \$525,318.15. To determine whether the services were allowable, we reviewed detailed transactions associated with those clients. We found services provided to 18 of those clients totaling \$169,455.42 were allowable because they were related to a medical emergency. However, services provided to 22 clients were not allowable because they did not relate directly to a medical emergency.

The table below summarizes unallowable services we found in our review of Medicaid expenditures for July 1, 2008 through June 30, 2009:

Service Description	Number of Clients	Total Questioned Costs (Total computable)	Federal Share	
			Non-ARRA Expenditures	ARRA Expenditures
Insurance premium payment	1	\$154.50	\$ 79.60	\$ -
Family planning services	1	\$708.27	\$ 364.90	\$ -
Assisted living and special medical equipment	2	\$66,931.07	\$ 34,190.61	\$ 5,134.59
Behavior rehabilitation services	3	\$91,680.40	\$ 46,897.67	\$ 5,659.40
Medicaid Personal Care Services	15	\$196,388.49	\$ 100,308.81	\$ 15,503.28
Total	22	\$355,862.73	\$ 181,841.59	\$ 26,297.27

Cause of Condition

The Department does not have an adequate procedure to differentiate state-funded care for the undocumented alien group from the regular Medicaid client group at the time of payment.

Because of this limitation, payments are charged to the Medicaid first. The Department then reviews the payments to identify any payments for non-emergency services. When they are identified, the Department removes the payments from the Medicaid. However, the Department does not identify all unallowable expenditures due to the fact that the review does not cover all AEM client groups and adjustments are processed manually.

Effect of Condition

The Department paid \$355,862.73 for the unallowable non-emergency services. We are questioning \$208,138.86, which is the federal portion of the expenditures.

Recommendation

We recommend the Department:

- Follow up on the non-emergency services provided to 22 undocumented aliens and work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid funds must be reimbursed.
- Establish and follow adequate procedure to ensure that Medicaid services provided to undocumented aliens are allowable under the Alien Emergency Medical program.

Department's Response

ADSA does not concur with this finding.

Seventeen of the exceptions were for undocumented alien clients who received services from ADSA however they did not receive services under the AEM program. Fifteen of the clients received Personal Care Services, 14 of which were minors who received those services from the Division of Developmental Disabilities. The minors were eligible for services under the state funded Categorically Needy Scope of Care which is allowed by RCW 74.09.520, WAC 388-501-0060(5) (w) and WAC 388-505-0210.

Three of the above were undocumented clients who received long term care services. The services were authorized through an exception to rule (ETR). State funded programs paid for the services these clients received.

All 17 of the ADSA clients were eligible for services that were 100% state-funded. For this reason, the ARRA enhanced match identified by the SAO did not affect the total state dollars to be expended for the programs.

Currently, tracking and maintaining cost adjustments to the federal share expenditures is a manual process requiring the use of spreadsheets to track the services received by individual clients. State dollars are journal vouchered back to the Medicaid programs after expenditures are identified. This process will become automated when the Provider One phase two project is implemented.

Health and Recovery Services Administration

HRSA does not concur with this finding.

The Department did not receive details for the claims relating to one client for insurance premiums and family planning services totaling \$863 to validate this finding. All medical related costs for individuals who are covered under the Alien Emergency Medical (AEM) program are charged to state only dollars. On a quarterly basis, the Department identifies by claim types and diagnoses codes, costs that are allowable for federal match and transfers those costs to earn federal match.

Auditor's Remarks

We appreciate the cooperation and assistance provided by the Department throughout the audit. Medicaid funds cannot be used for aliens except for services necessary in an emergency medical situation. For the exceptions we identified Medicaid funds were used to provide medical services to aliens. However, none of the services directly related to a medical emergency. We will review this area during our next audit.

Applicable Laws and Regulations

§ 435.139 Coverage for certain aliens states:

The agency must provide services necessary for the treatment of an emergency medical condition, as defined in §440.255(c) of this chapter, to those aliens described in §435.406(c) of this subpart.

Title 42 CFR 440.255, Limited services available to certain aliens states:

- (a) FFP for services. FFP is available for services provided to aliens described in this section which are necessary to treat an emergency medical condition as defined in paragraphs (b)(1) and (c) or services for pregnant women described in paragraph (b)(2).
- (b) Legalized aliens eligible only for emergency services and services for pregnant women. Aliens granted lawful temporary resident status, or lawful permanent resident status under sections 245A, 210 or 210A of the Immigration and Nationality Act, who are not in one of the exempt groups described in §§435.406(a)(3) and 436.406(a)(3) and who meet all other requirements for Medicaid will be eligible for the following services—
 - (1) Emergency services required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
 - (i) Placing the patient's health in serious jeopardy;
 - (ii) Serious impairment to bodily functions; or
 - (iii) Serious dysfunction of any bodily organ or part.
 - (2) Services for pregnant women which are included in the approved State plan. These services include routine prenatal care, labor and delivery, and routine post-partum care. States, at their option, may provide additional plan services for the treatment of conditions which may complicate the pregnancy or delivery.
- (c) Effective January 1, 1987, aliens who are not lawfully admitted for permanent residence in the United States or permanently residing in the United States under the color of law must receive the services necessary to treat the condition defined in paragraph (1) of this section if—
 - (1) The alien has, after sudden onset, a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
 - (i) Placing the patient's health in serious jeopardy;

- (ii) Serious impairment to bodily functions; or
- (iii) Serious dysfunction of any bodily organ or part, and
- (2) The alien otherwise meets the requirements in §§435.406(c) and 436.406(c) of this subpart.

Title 42 CFR 435.406, Citizenship and alienage states:

- (a) The agency must provide Medicaid to otherwise eligible residents of the United States who are —
 - (1) Citizens:
 - (i) Under a declaration required by section 1137(d) of the Act that the individual is a citizen or national of the United States; and
 - (ii) The individual has provided satisfactory documentary evidence of citizenship or national status, as described in §435.407.
 - (iii) An individual for purposes of the declaration and citizenship documentation requirements discussed in paragraphs (a)(1)(i) and (a)(1)(ii) of this section includes both applicants and recipients under a section 1115 demonstration (including a family planning demonstration project) for which a State receives Federal financial participation in their expenditures, as though the expenditures were for medical assistance.
 - (iv) Individuals must declare their citizenship and the State must document the individual's citizenship in the individual's eligibility file on initial applications and initial redeterminations effective July 1, 2006.
 - (v) The following groups of individuals are exempt from the requirements in paragraph (a)(1)(ii) of this section:
 - (A) Individuals receiving SSI benefits under title XVI of the Act.
 - (B) Individuals entitled to or enrolled in any part of Medicare.
 - (C) Individuals receiving disability insurance benefits under section 223 of the Act or monthly benefits under section 202 of the Act, based on the individual's disability (as defined in section 223(d) of the Act).
 - (D) Individuals who are in foster care and who are assisted under Title IV-B of the Act, and individuals who are recipients of foster care maintenance or adoption assistance payments under Title IV-E of the Act.
 - (2)
 - (i) Except as specified in 8 U.S.C. 1612(b)(1) (permitting States an option with respect to coverage of certain qualified aliens), qualified aliens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) (including qualified aliens subject to the 5-year bar) who have provided satisfactory documentary evidence of Qualified Alien status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or recipient is an alien in a satisfactory immigration status.
 - (ii) The eligibility of qualified aliens who are subject to the 5-year bar in 8 U.S.C. 1613 is limited to the benefits described in paragraph (b) of this section.
- (b) The agency must provide payment for the services described in §440.255(c) of this chapter to residents of the State who otherwise meet the eligibility requirements of the State plan (except for receipt of AFDC, SSI, or State Supplementary payments) who are qualified aliens subject to the 5-year bar or who are non-qualified aliens who meet all Medicaid eligibility criteria, except non-qualified aliens need not present a social security number or document immigration status.

WAC 388-500-0005, Medical definitions states in part:

"Emergency medical condition" means the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- *Placing the patient's health in serious jeopardy;
- *Serious impairment to bodily functions; or
- *Serious dysfunction of any bodily organ or part.

WAC 388-438-0110, the alien emergency medical (AEM) program states:

- (1) The alien emergency medical (AEM) program is a required federally funded program. It is for aliens who are ineligible for other medicaid programs, due to the citizenship or alien status requirements described in WAC [388-424-0010](#)
- (2) Except for the Social Security number, citizenship, or alien status requirements, an alien must meet categorical medicaid eligibility requirements as described in:
 - (a) WAC [388-505-0110](#), for an SSI-related person;
 - (b) WAC [388-505-0220](#), for family medical programs;
 - (c) WAC [388-505-0210](#), for a child under the age of nineteen; or
 - (d) WAC [388-523-0100](#), for medical extensions.
- (3) When an alien has monthly income that exceeds the CN medical standards, the department will consider AEM medically needy coverage for children or for adults who are age sixty-five or over or who meet SSI disability criteria. See WAC [388-519-0100](#).
- (4) To qualify for the AEM program, the alien must meet one of the criteria described in subsection (2) of this section and have a qualifying emergency medical condition as described in WAC [388-500-0005](#).
- (5) The alien's date of arrival in the United States is not used when determining eligibility for the AEM program.
- (6) The department does not deem a sponsor's income and resources as available to the client when determining eligibility for the AEM program. The department counts only the income and resources a sponsor makes available to the client.
- (7) Under the AEM program, covered services are limited to those medical services necessary for treatment of the person's emergency medical condition. The following services are not covered:
 - (a) Organ transplants and related services;
 - (b) Prenatal care, except labor and delivery;
 - (c) School-based services;
 - (d) Personal care services;
 - (e) Waiver services;
 - (f) Nursing facility services, unless they are approved by the department's medical consultant; and
 - (g) Hospice services, unless they are approved by the department's medical consultant.
- (8) The medical service limitations and exclusions described in subsection (7) also apply under the MN program.
- (9) A person determined eligible for the AEM program is certified for three months. The number of three-month certification periods is not limited, but, the person must continue to meet eligibility criteria in subsection (2) and (4) of this section.
- (10) A person is not eligible for the AEM program if that person entered the state specifically to obtain medical care.

09-28 The Department of Social and Health Services' internal controls are inadequate to ensure the federal share of overpayments made to Medicaid providers are refunded to the federal government in a timely manner.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care
Providers and Suppliers
93.778 Medical Assistance Program (Medicaid; Title XIX)
93.778 Medical Assistance Program (Medicaid; Title XIX) –
American Recovery and Reinvestment Act (ARRA)
Federal Award Number: 5-0905WA5028, 5-0905W5048, 5-0905WAARRA
Applicable Compliance Component: Allowable Costs/Cost Principles
Questioned Cost Amount: None

Background

Most Medicaid expenditures are payments to providers of medical treatment, prescriptions, medical equipment, home health care, and other services. Providers submit payment claims to the Department of Social and Health Services. Since October 1, 2008, these payments are eligible for increased Federal Medical Assistance Percentage (FMAP) due to the American Recovery and Reinvestment Act of 2009. This means the state receives more funding for eligible expenditures - from approximately 50 percent previously to now over 60 percent.

The Department has a number of post-payment audits designed to identify and recover inappropriate payments, which are referred to as overpayments. When overpayments are discovered, the Department is required to pay back to the federal government its share of overpayments within 60 days of the date of discovery, even if the state has not recovered the overpayment from the provider. The state does not have to refund the overpayment if the provider has filed for bankruptcy or has gone out of business.

The federal Medicaid program is operated on a reimbursement basis, meaning the state pays program costs and then submits a claim to the federal government to recover those costs. Because of this, payments owed to the federal government are made by reducing the amount of the reimbursement requested.

In our audits for fiscal years 2005 through 2008, we reported findings relating to the Department's inadequate controls over overpayment refunding.

The state had Medicaid expenditures of approximately \$6.8 billion in fiscal year 2009, \$4.1 billion of which was federal dollars.

Description of Condition

We reviewed 16 individually significant items of the 150 overpayments the Department identified in fiscal year 2009. While we found improvements during the current audit, we still found deficiencies in internal controls designed to ensure the federal portion of provider overpayments was refunded to the federal government as regulations require:

Inadequate procedures

The Department does not have adequate procedures to ensure the federal share of overpayments is refunded within 60 days of discovery. When the Department's Office of Financial Recovery establishes accounts receivable, the 60-day clock starts. If a balance remains on day 61, the system runs a Medicaid Overpayment Management System report that is forwarded to the Office of Accounting Services (OAS) to process the refunds of any amount still owed to the federal government. OAS processes refunds from these reports once a month. Because of this, it may take up to 90 days for refunds to be sent to the federal government. The Department stated its federal grantor indicated it would not take issue with these instances of late refunds due to the timing of the Department's processing.

Lack of Monitoring

The Department is not adequately monitoring to ensure the federal share of overpayments is refunded in a timely manner. Nine of 16, or 56 percent of the overpayments were refunded more than 90 days after the date of discovery.

The table summarizes the results of our work:

	Total Samples Selected	Overpayments Refunded				
		0-60 Days		60-90 Days		Exceeding 90 Days
		In Compliance	Exceptions	Percentage	Exceptions	Percentage
Overpayments refunded by DSHS	16	2	5	31%	9	56%
Amounts	\$2,236,963.46	\$318,375.80	\$886,121.04	40%	\$1,032,466.62	46%

Cause of Condition

Inadequate procedures

The timing of the Department’s internal processes often prevents it from complying with federal requirements for refunding overpayments. This issue appears to be inherent in the Department’s system and may not be easily remedied.

Lack of monitoring

The Department stated some overpayments were not refunded in a timely manner because new staff in training, increased workloads, and significant cuts in the division that processes overpayment refunding.

The Department did not have clearly defined procedures that allow it to be consistent in processing overpayments nor did the Department have management responsible for overseeing the entire overpayment processes.

Effect of Condition

Inadequate procedures

The Department is not in compliance with the federal regulations. However, the federal grantor has indicated it would not take issue with these refunds occurring between 60 and 90 days.

Lack of monitoring

We found nine overpayments, totaling \$1,032,466.62 were refunded to the federal government more than 90 days after date of discovery. The lateness of these refunds would not be attributed to the Department’s process timing, but rather to inadequate monitoring of the reporting requirements.

By not reporting overpayments in a timely manner, the Department effectively denied the grantor the use of funds that would have otherwise been available for the Medicaid program.

Recommendation

We recommend the Department:

- Establish adequate procedures to ensure the federal share of overpayments is refunded within 60 days of discovery.
- Monitor to ensure all overpayments are refunded to the federal government in a timely manner.
- Train staff members to ensure they adequately perform duties related to overpayment refunding.
- Work with the U.S. Department of Health and Human Services to provide assurances, to the grantor’s satisfaction, that the federal share of overpayments has been properly refunded.

Department's Response

The Department does not concur with this finding.

The Department had a similar finding in SFY08 (08-20) and the Department previously discussed the process with the Centers for Medicare and Medicaid Services (CMS) auditor. The CMS auditor did not raise internal control concerns regarding the Departments accuracy and timeliness for refunding the federal share of overpayments to the federal government.

The CMS auditor reviewed the quarterly CMS-64 claim report and has reviewed our accounting processes and procedures that create the CMS-64. Since the Department's Medicaid overpayment process is acceptable by CMS, the Department does not see a beneficial reason to change the process.

Significant staff training occurred within the last year and has proven successful in addressing the issues from the previous audit finding. Therefore, the Department does not concur that staff training is necessary to respond to this audit finding.

Auditor's Remarks

We thank the Department for its response, and will follow up during our next audit.

Applicable Laws and Regulations

Circular No. A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Subpart C, §_300 Auditee responsibilities. states in part:

The auditee shall:

- (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.

42 CFR 433.312 Basic requirements for refunds.

(a) Basic rules.

- (1) Except as provided in paragraph (b) of this section, the Medicaid agency has 60 days from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to CMS.
- (2) The agency must refund the Federal share of overpayments at the end of the 60-day period following discovery in accordance with the requirements of this subpart, whether or not the State has recovered the overpayment from the provider.

(b) Exception.

The agency is not required to refund the Federal share of an overpayment made to a provider when the State is unable to recover the overpayment amount because the provider has been determined bankrupt or out of business in accordance with Sec. 433.318.

(c) Applicability.

- (1) The requirements of this subpart apply to overpayments made to Medicaid providers that occur and are discovered in any quarter that begins on or after October 1, 1985.
- (2) The date upon which an overpayment occurs is the date upon which a State, using its normal method of reimbursement for a particular class of provider (e.g., check, interfund transfer), makes the payment involving unallowable costs to a provider.

42 CFR 433.318 Overpayments involving providers who are bankrupt or out of business.

(a) Basic rules.

- (1) The agency is not required to refund the Federal share of an overpayment made to a provider as required by Sec. 433.312(a) to the extent that the State is unable to

- recover the overpayment because the provider has been determined bankrupt or out of business in accordance with the provisions of this section...
- (b) Overpayment debts that the State need not refund. Overpayments are considered debts that the State is unable to recover within the 60-day period following discovery if the following criteria are met:
 - (1) The provider has filed for bankruptcy, as specified in paragraph (c) of this section; or
 - (2) The provider has gone out of business and the State is unable to locate the provider and its assets, as specified in paragraph (d) of this section...
 - (e) Circumstances requiring refunds. If the 60-day recovery period has expired before an overpayment is found to be uncollectible under the provisions of this section, if the State recovers an overpayment amount under a court-approved discharge of bankruptcy, or if a bankruptcy petition is denied, the agency must refund the Federal share of the overpayment in accordance with the procedures specified in Sec. 433.320.

42 CFR 433.320 Procedures for refunds to CMS.

- (a) Basic requirements.
 - (1) The agency must refund the Federal share of overpayments that are subject to recovery to CMS through a credit on its Quarterly Statement of Expenditures (Form CMS-64).
 - (2) The Federal share of overpayments subject to recovery must be credited on the Form CMS-64 report submitted for the quarter in which the 60-day period following discovery, established in accordance with Sec. 433.316, ends.
 - (3) A credit on the Form CMS-64 must be made whether or not the overpayment has been recovered by the State from the provider.
- (b) Effect of reporting collections and submitting reduced expenditure claims.
 - (1) The State is not required to refund the Federal share of an overpayment when the State reports a collection or submits an expenditure claim reduced by a discrete amount to recover an overpayment prior to the end of the 60-day period following discovery.
 - (2) The State is not required to report on the Form CMS-64 any collections made on overpayment amounts for which the Federal share has been refunded previously.
 - (3) If a State has refunded the Federal share of an overpayment as required under this subpart and the State subsequently makes recovery by reducing future provider payments by a discrete amount, the State need not reflect that reduction in its claim for Federal financial participation...
- (d) Expiration of 60-day recovery period. If an overpayment has not been determined uncollectible in accordance with the requirements of Sec. 433.318 at the end of the 60-day period following discovery of the overpayment, the agency must refund the Federal share of the overpayment to CMS in accordance with the procedures specified in paragraph (a) of this section.

09-29 The Department of Social and Health Services did not ensure all individuals who receive Medicaid benefits have valid Social Security numbers.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care
Providers and Suppliers
93.778 Medical Assistance Program (Medicaid; Title XIX)
93.778 Medical Assistance Program (Medicaid; Title XIX) –
American Recovery and Reinvestment (ARRA)
Federal Award Number: 5-0905WA5028, 5-0905W5048, 5-0905WAARRA
Applicable Compliance Component: Eligibility
Questioned Cost Amount: \$169,063.20

Background

Medicaid is a state and federal partnership that provides coverage for certain low-income individuals who might otherwise go without medical care. The state Medicaid program spent more than \$6.8 billion during fiscal year 2009; approximately \$4.1 billion was paid with federal funds.

Federal regulations require the Department to obtain a Social Security number from each individual, including children, applying for Medicaid services. Federal regulations also require the Department to verify the number given with the Social Security Administration to ensure it was issued to the individual who supplied it and whether any other number had been issued for the individual. If an applicant has not been issued a number, the Department must assist the individual in applying for one. Under these circumstances, the Department must obtain evidence to establish the age, citizenship or immigration status, and the true identity of the applicant.

The Social Security Administration provides the state with access to a computer system called the State On-line Query (SOLQ) that enables the Department to verify the validity of a Social Security number at the time of application. Department policy requires staff to verify a client-provided Social Security number using the SOLQ system.

Along with the use of SOLQ, every Social Security number entered in the Automated Client Eligibility System (ACES) is sent in an overnight batch to the Social Security Administration for verification. If it cannot verify a number, the Administration sends an electronic message, to the DSHS Community Service Office.

Description of Condition

We reviewed all Social Security numbers of Medicaid beneficiaries in the Department's two Medicaid claim processing systems; Medicaid Management Information system (MMIS) and Social Service Payment System (SSPS), and independently verified all Social Security numbers in those systems by running a computerized cross-match with the Social Security Administration's database.

Invalid Social Security Numbers

We initially identified 439 Social Security numbers which, according to the Social Security Administration's database, have never been issued and are therefore invalid. The Department was able to resolve 414 of these; most were due to data entry errors or other factors that explained the situation. Twenty-five remain unresolved.

No Social Security Numbers in the MMIS and SSPS

For some Medicaid client groups, such as foster/adoption children, the Department does not maintain the client's Social Security number in the payment systems due to client confidentiality. As such, not finding a client's Social Security number in the MMIS and SSPS does not always mean the Department does not have a valid Social Security number for the client.

We found 7,612 clients that had no Social Security numbers in the systems. We randomly selected 146 and did work to determine whether they have valid Social Security numbers. The Department was able to resolve 91 of those. Fifty-five remain unresolved.

Social Security Numbers belong to deceased people

We used Computer Assisted Auditing Techniques to identify payments for services provided to individuals using the Social Security number of a deceased person and found 676 clients who met that criteria. After performing an initial review of the 676, we focused additional work on 181 clients who did not appear to be related to the deceased individual whose number was being used. We have found that while misuse by relatives can occur, these instances often involved spouses legitimately using a deceased spouse’s number. Further review by our Office and the Department resolved 171 of the 181 clients selected. Ten remain unresolved.

The table below summarizes the unresolved instances and related Medicaid expenditures:

The Department was unable to locate a valid SSN for the client	MMIS		SSPS	
	Number of Social Security numbers	Payments	Number of Social Security numbers	Payments
Invalid SSN	16	\$37,411.76	9	\$201,032.74
No SSN	55	\$78,897.63	0	\$0.00
SSN belongs to deceased people	10	\$20,784.27	0	\$0.00
Total	81	\$137,093.66	9	\$201,032.74

The total expenditure the Department paid for the services that were provided the 90 clients who did not have valid Social Security numbers was \$338,126.40.

Cause of Condition

Not all eligibility workers are following the Department’s Social Security number verification procedures. While the Department has made improvements, staff training and monitoring by management are not preventing or catching all exceptions.

Effect of Condition

When Medicaid benefits are provided to ineligible individuals, expenditures are not allowable, and the money available for eligible clients is reduced. Payments for services for these 90 clients were \$338,032.74. We are questioning the federal portion of the questioned costs. Under federal laws and regulations, a disallowance of federal payments for Medicaid eligibility errors can occur only if the errors are detected through a State’s Medicaid Eligibility Quality Control program, a federally mandated Medicaid eligibility review process. Because of this, we are not recommending the Department refund the federal portion of payments associated with the services for those clients to the federal government.

Recommendation

We recommend the Department:

- Follow up on 90 clients for whom the Department could not give us evidence of correct Social Security Numbers.
- Ensure all eligibility workers are following the Department’s Social Security number verification procedures.

Department's Response

The Department (Children's Administration, Economic Services Administration, and Health and Recovery Services Administration) partially concurs with this finding.

The Department is committed to accurately and timely service for eligible applicants for Medicaid.

Economic Services Administration (ESA) and Health and Recovery Services Administration (HRSA)

- *Of the 90 exceptions sited, the Department agrees that 76 were in error; thirteen clients had the correct Social Security number in the system or the Social Security number was not needed because of particular program requirements, and the remaining one client was counted twice.*
- *Of the 76 cases that were in error, 17 cases were Take Charge applications. The Take Charge application is completed and stored at providers' offices. Currently, when the case is opened these clients receive a paper Eligibility Card that verifies their eligibility for a full year. Once eligibility is processed and the card is issued, the eligibility cannot be closed. HRSA's contact with TakeCharge clients is very limited, as in many cases the Administration must work through the Family Planning clinics. Most of the clients who have not provided SSNs are minors who use the Family Planning clinic as their payee. HRSA has not been successful in their attempts to correct the SSNs. The next step would be to propose termination, which they cannot currently do. However, they do not recertify them without a federally verified Social Security number. HRSA is implementing a new Medicaid payment system, ProviderOne, in 2010. With ProviderOne, the Department will move to the issuance of an electronic benefits card which will make it possible to close the TakeCharge cases upon notice of invalid SSN.*
- *Only 9 cases are open and the Department will take immediate action to correct the SSNs. The remaining 80 cases are currently closed and cannot be acted upon as the Department does not have means to contact these clients and get updated information. The Department has documented the need for valid SSNs in the record, and will correct them if and when the client re-applies for Medicaid benefits.*
- *To address the finding that not all eligibility workers follow the Department's SSN verification procedures, an interactive training module is being developed to educate the staff and test their measure of comprehension. The training will be completed and available by April 30, 2010. A memo will be sent to the field requiring all financial staff complete the training by August 30, 2010.*

Children's Administration (CA)

CA agrees that some of the SSN's are invalid. Of the nine exceptions identified for CA, six are for children who did not receive Medicaid and hence did not go through the process identified last year to verify SSN's. The remaining three are payments made using a temporary SSN of 123456789. This temporary SSN is used to get payments out timely. Once the valid SSN is determined, the information is updated in the system.

Auditor's Remarks

We appreciate the cooperation and assistance provided by the Department throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

The Code of Federal Regulations is explicit regarding obtaining and verifying Social Security numbers as a condition of Medicaid eligibility. 42 CFR 435.910 (a) specifically states in part:

The agency must require, as a condition of eligibility that each individual (including children) requesting Medicaid services furnish each of his or her own social security numbers

42 CFR 435.910 (g) states:

The agency must verify each SSN of each applicant and recipient with SSA, as prescribed by the commissioner, to insure that each SSN furnished was issued to that individual and to determine whether any others were issued.

If a Medicaid applicant cannot remember or has not been issued a Social Security number, 42 CFR 435.910 (e) (1-3) states that the agency must:

- (1) Assist the applicant in completing an application for an SSN;
- (2) Obtain evidence required under SSA regulations to establish the age, the citizenship or alien status, and the true identity of the applicant; and
- (3) Either send the application to SSA or, if there is evidence that the applicant has previously been issued a SSN, request SSA to furnish the number.

42 CFR 435.916 (a) states in part:

The agency must re-determine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months . . .

42 CFR 435.920 (a-c) states:

- (a) In re-determining eligibility, the agency must review case records to determine whether they contain the recipient's SSN or, in the case of families, each family member's SSN.
- (b) If the case record does not contain the required SSNs, the agency must require the recipient to furnish them and meet other requirements of 435.910.

If the agency initially established eligibility without verification of the Social Security number, 42 CFR 435.920 (c) requires:

For any recipient whose SSN was established as part of the case record without evidence required under the SSN regulations as to age, citizenship, alien status, or true identity, the agency must obtain verification of these factors in accordance with 435.910.

The Medicaid State Plan incorporates the above references as applicable to Washington State's coverage and eligibility criteria when it states the following:

The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

09-30 The Department of Social and Health Services, Aging and Disability Services Administration, did not evaluate or re-evaluate the level of in-home care services for some clients at least annually.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
 93.775 State Medicaid Fraud Control Units
 93.776 Hurricane Katrina Relief
 93.777 State Survey and Certification of Health Care Providers and Suppliers
 93.778 Medical Assistance Program (Medicaid; Title XIX)
 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment (ARRA)
Federal Award Number: 5-0905WA5028, 5-0905W5048, 5-0905WAARRA
Applicable Compliance Component: Utilization Control and Program Integrity
Questioned Cost Amount: \$ 184,907.23

Background

The Department of Social Health Services, Aging and Disability Services Administration, requires all clients who seek Medicaid assistance to meet eligibility criteria prior to receiving services. Eligibility is determined in part through an assessment of the client’s level of ability to perform daily living tasks.

The Department uses the Comprehensive Assessment Reporting Evaluation system to determine the type and level of services the client needs. Home and Community Service offices do an initial evaluation; case managers at the Area Agency on Aging agencies are to re-evaluate clients annually.

The annual re-evaluation is designed to determine if the level of care is appropriate and if clients are still eligible to receive assistance. Evaluations are considered complete and the client is authorized to receive services once the client has reviewed the results of his or her assessment and has either verbally agreed to or given a signature of approval for the services.

In fiscal year 2008 the Department provided funding for services to more than 16,000 clients.

Description of Condition

The Department did not monitor to ensure staff was completing evaluations for all clients receiving long-term services in a timely manner. During our audit, we identified 618 clients whose assessment was at least 30 days late.

Case managers are given until the last day of the month in which the previous assessment occurred. This means in some cases, assessments may not be performed until nearly 30 days after the standard 12 months. We acknowledge the extended time case managers are allowed and only considered those assessments occurring after 13 months as issues.

The table below summarizes the assessments we identified in our review as being completed after the annual re-evaluation due date:

Duration of Time Exceeding Annual Assessment Date:	Number of Assessments
One Month	406
Two Months	85
Three Months	41
Four Months	30
Five Months	12
Six Months or Greater	44
Total	618

Cause of Condition

The Department stated routine reasons such as the client's inability to meet with the case manager, delays in locating a personal care provider or obtaining bids for specialized medical equipment or environmental modifications can result in an untimely assessment. To improve the process, the Department distributed a Management Bulletin to field staff emphasizing the need for a timely assessment and procedures to be used.

While the Department has made improvements, management was not able to monitor all cases to ensure evaluations or re-evaluations of level of care for clients were performed at least once every 12 months.

Effect of Condition

When services are provided without authorization, expenditures are not allowable. We reviewed payments for services for 56 clients whose assessment was at least five months late. Total payments after the re-evaluation due date for these clients were \$301,923.65. We are questioning \$184,907.23, which is the federal portion of the expenditures.

Recommendation

We recommend the Department:

- Monitor to ensure level of care assessment for clients receiving in-home care is performed at least once every 12 months.
- Work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid funds must be reimbursed.

Department's Response

The Department concurs with this finding.

For this audit cycle, the SAO found that 618 assessments out of 57,597 appeared to be late. Due to staff reductions, the Department was not able to complete a line by line review of all 618 assessments. There are routine reasons that an assessment may not be completed on time. Examples of these reasons include the client's inability to meet with the case manager to do the assessment, delays in locating a provider of personal care, referrals triggered by the skin observation protocol, and delays caused by bids for specialized medical equipment or environmental modifications. A client may also have been admitted to a nursing facility or hospital or had a break in service nullifying the annual assessment due date.

During this audit cycle, the Department completed 57,597 assessments. If 618 of these assessments were actually late, this amounts to a compliance rate of 98.9% which is well within an acceptable threshold given the routine reasons why an assessment could be late. Currently, the Department has set a benchmark of 90% for compliance with assessment timeliness. This benchmark is measured during each quality monitoring cycle and was surpassed during this audit period when 95% compliance was achieved.

§ *In 2010, the Department will review the current benchmark of 90% to ensure that it remains a reasonable threshold of compliance.*

§ *In 2010, the Department will work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid funds must be reimbursed. The Aging and Disability Services Administration does not believe there are any questioned costs because all clients were eligible for services received.*

Auditor's Remarks

We appreciate the cooperation and assistance provided by the Department throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

COPEs Waiver Version 06-95 states in part:

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in the Executive Summary of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (check all that apply):

- Discharge planning team
- Physician (MD or DO)
- Registered nurse, licensed in the state
- Licensed social worker
- Qualified mental retardation professional, as defined in 42 CFR 483.430(a)
- Other (specify):
Social Workers, Case Managers

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (specify):

- Every 3 months
- Every 6 months
- Every 12 months
- Other (specify):
As indicated by a significant change in the client's condition or situation

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

- The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.
- The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for all individuals performing reevaluations of level of care (specify):
 - Physician (MD or DO)
 - Registered nurse, licensed in the state
 - Licensed social worker
 - Qualified mental retardation professional, as defined in 42 CFR 483.430(a)
 - Other (specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The state will employ the following procedures to ensure timely reevaluations of level of care (check below):

- "Tickler" file Edits in computer system
 Component part of case management
 Other (specify):

Quality assurance monitoring staff from ADSA headquarters conducts annual reviews of case management services provided by the Home and Community Services Division (HCS), Area Agencies on Aging (AAA) and Managed Care Organizations (MCO). Each HCS region ,AAA office and MCO is monitored. At the regional and local levels, HCS and AAA case management supervisors also conduct regular quality reviews of their case management staff.

42 C.F.R. 441.302 State assurances.

Unless the Medicaid agency provides the following satisfactory assurances to CMS, CMS will not grant a waiver under this subpart and may terminate a waiver already granted:

- (a) *Health and Welfare* —Assurance that necessary safeguards have been taken to protect the health and welfare of the recipients of the services. Those safeguards must include—
- (1) Adequate standards for all types of providers that provide services under the waiver;
 - (2) Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver; and
 - (3) Assurance that all facilities covered by section 1616(e) of the Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
- (b) *Financial accountability*— The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.
- (c) *Evaluation of need*. Assurance that the agency will provide for the following:
- (1) *Initial evaluation*. An evaluation of the need for the level of care provided in a hospital, a NF, or an ICF/MR when there is a reasonable indication that a recipient might need the services in the near future (that is, a month or less) unless he or she receives home or community-based services. For purposes of this section, “evaluation” means a review of an individual recipient's condition to determine—
 - (i) If the recipient requires the level of care provided in a hospital as defined in §440.10 of this subchapter, a NF as defined in section 1919(a) of the Act, or an ICF/MR as defined by §440.150 of this subchapter; and
 - (ii) That the recipient, but for the provision of waiver services, would otherwise be institutionalized in such a facility.
 - (2) *Periodic reevaluations*. Reevaluations, at least annually, of each recipient receiving home or community-based services to determine if the recipient continues to need the level of care provided and would, but for the provision of waiver services, otherwise be institutionalized in one of the following institutions:
 - (i) A hospital;
 - (ii) A NF; or
 - (iii) An ICF/MR.

- (d) *Alternatives* —Assurance that when a recipient is determined to be likely to require the level of care provided in a hospital, NF, or ICF/MR, the recipient or his or her legal representative will be—
 - (1) Informed of any feasible alternatives available under the waiver; and
 - (2) Given the choice of either institutional or home and community-based services.
- (e) *Average per capita expenditures.* Assurance that the average per capita fiscal year expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made in the fiscal year for the level of care provided in a hospital, NF, or ICF/MR under the State plan had the waiver not been granted.
 - (1) These expenditures must be reasonably estimated and documented by the agency.
 - (2) The estimate must be on an annual basis and must cover each year of the waiver period.
- (f) *Actual total expenditures.* Assurance that the agency's actual total expenditures for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to recipients under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals, absent the waiver, in—
 - (1) A hospital;
 - (2) A NF; or
 - (3) An ICF/MR.
- (g) *Institutionalization absent waiver.* Assurance that, absent the waiver, recipients in the waiver would receive the appropriate type of Medicaid-funded institutional care (hospital, NF, or ICF/MR) that they require.
- (h) *Reporting.* Assurance that annually, the agency will provide CMS with information on the waiver's impact. The information must be consistent with a data collection plan designed by CMS and must address the waiver's impact on—
 - (1) The type, amount, and cost of services provided under the State plan; and
 - (2) The health and welfare of recipients.
- (i) *Habilitation services.* Assurance that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver, are—
 - (1) Not otherwise available to the individual through a local educational agency under section 602 (16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401 (16 and 17)) or as services under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730); and
 - (2) Furnished as part of expanded habilitation services, if the State has requested and received CMS's approval under a waiver or an amendment to a waiver.
- (j) *Day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services for individuals with chronic mental illness.* Assurance that FFP will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are—
 - (1) Age 22 to 64;
 - (2) Age 65 and older and the State has not included the optional Medicaid benefit cited in §440.140; or
 - (3) Age 21 and under and the State has not included the optional Medicaid benefit cited in §440.160.

[50 FR 10026, Mar. 13, 1985, as amended at 59 FR 37717, July 25, 1994; 65 FR 60107, Oct. 10, 2000]

WAC 388-106-0025

How do I apply for long-term care services?

To apply for long-term care services, you must request an assessment from the department and submit a Medicaid application.

WAC 388-106-0050

What is an assessment?

- (1) An assessment is an in-person interview in your home or your place of residence that is conducted by the department to inventory and evaluate your ability to care for yourself. The department will assess you at least annually or more often when there are significant changes to your ability to care for yourself.
- (2) Between assessments, the department may modify your current assessment without an in-person interview in your home or place of residence. The reasons that the department may modify your current assessment without conducting an in-person interview in your home or place of residence include but are not limited to the following:
 - (a) Errors made by department staff in coding the information from your in-person interview;
 - (b) New information requested by department staff at the time of your assessment and received after completion of the in-person interview (e.g. medical diagnosis);
 - (c) Changes in the level of informal support available to you; or
 - (d) Clarification of the coding selected.
- (3) When the department modifies your current assessment, it will notify you using a Planned Action Notice of the modification regardless of whether the modification results in a change to your benefits. You will also receive a new service summary and assessment details.

WAC 388-106-0055

What is the purpose of an assessment?

The purpose of an assessment is to:

- (1) Determine eligibility for long-term care programs;
- (2) Identify your strengths, limitations, and preferences;
- (3) Evaluate your living situation and environment;
- (4) Evaluate your physical health, functional and cognitive abilities;
- (5) Determine availability of informal supports and other nondepartment paid resources;
- (6) Determine need for intervention;
- (7) Determine need for case management activities;
- (8) Determine your classification group that will set your payment rate for residential care or number of hours of in-home care;
- (9) Determine need for referrals; and
- (10) Develop a plan of care, as defined in WAC 388-106-0010.
- (11) In the case of New Freedom consumer directed services, the purpose of an assessment is to determine functional eligibility and for the participant to develop the New Freedom spending plan, as defined in WAC 388-106-0010.

WAC 388-513-1315 states in part:

Eligibility for long-term care (institutional, waiver, and hospice) services.

This section describes how the department determines a client's eligibility for institutional, waiver, or hospice services under the categorically needy (CN) program and institutional or hospice services in a medical institution under the medically needy (MN) program. Also described are the eligibility requirements for these services under the general assistance (GA) program in subsection (12) and the alien emergency medical programs described in subsection (11).

- (1) To be eligible for long-term care (LTC) services described in this section, a client must:
 - (a) Meet the general eligibility requirements for medical programs described in WAC 388-503-0505 (2) and (3)(a) through (f);
 - (b) Attain institutional status as described in WAC 388-513-1320;
 - (c) Meet functional eligibility described in chapter 388-106 WAC for waiver and nursing facility coverage; and

DSHS Long-Term Care Manual Chapter 3 states in part:

Completing a CARE Assessment – Developing the Plan of Care

Background

Clients are able to choose from options for personal and healthcare services that are governed by eligibility criteria, payment source requirements, coverage options, and provider qualifications. Twenty-four hour, paid care is available only in residential or medical facility settings, so case managers must work with clients to maximize all available resources, both paid and unpaid, in order to develop a plan of care that addresses the health and safety needs of the client. The state identifies the essential tasks to be performed by formal providers in the care plan. How and when they are performed is determined by the client.

The state has an obligation to educate clients, family members, support systems, and other service providers, informing them that a plan of care is developed based on the resources available and that meeting all needs and providing all services is an expectation that neither the client, family, support system, or case manager may be able to achieve.

How do I get approval on the plan of care from the client?

Before authorizing services, you must obtain the client's approval on the plan of care.

How do I distribute the plan of care to the client/representative?

Distribute the Service Summary and CARE Results to the client along with a Planned Action Notice (PAN). Distribute Assessment Details if requested by the client/representative.

How and when do I distribute the plan of care to the provider(s)?

Mail or fax the Service Summary and Assessment Details prior to authorizing/reauthorizing services and document in the SER. Review the plan of care with the provider when the client has special or extraordinary needs due to cognitive issues. Distribute the Service Summary and Assessment Details to:

- Individual providers;
- Agency providers;
- Nursing services staff, if applicable;
- Residential providers;
- The nursing facility, if the client is placed there on Medicaid funding only;
- Adult Day Services providers;
- Nurse delegators.

Document in the SER when you distributed the documents and to whom.

How do I authorize services?

Complete all authorizations in CARE once the client has approved the plan of care. For:

- Initial assessments, the begin date may not precede the date the assessment was moved to *Current* status.
- Significant Change assessments, if extending services for one year, terminate the current line or lines (for example, if participation is also authorized) and create a new line(s) on the same authorization. Do not change the begin date on a current line since changing the begin date creates a risk of canceling outstanding payments or prevents invoicing from occurring. If there are not enough lines left on the authorization, open a new authorization.
- Annual assessments, you may not extend services beyond one year from the last day of the month in which it was moved to *Current*. A face-to-face assessment must occur and the assessment must be moved to *Current* prior to reauthorization of services.

09-31 The Department of Social and Health Services' internal controls are inadequate to ensure non-emergency medical transportation expenditures are allowable and adequately supported.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care Providers and Suppliers
93.778 Medical Assistance Program (Medicaid; Title XIX)
93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment (ARRA)
Federal Award Number: 5-0905WA5028, 5-0905W5048, 5-0905WAARRA
Applicable Compliance Component: Activities Allowed/Unallowed, Allowable Costs/Cost Principles
Questioned Cost Amount: None

Background

The Department of Social and Health Services provides eligible Medicaid recipients transportation to and from non-emergency, medically necessary appointments. Medicaid clients who qualify are provided transportation or are reimbursed for travel costs. The appointments must be for services the Medicaid program pays for.

Transportation services include public transit, client and volunteer mileage reimbursement, wheel chair- equipped vans, taxis, ferries and fuel vouchers. In less frequent cases, if out-of-state transportation is necessary, lodging and food may be included.

Since 1989, Washington State has used a brokerage system to provide non-emergency medical transportation for eligible Medicaid clients. Brokers contract with DSHS to deal directly with the clients to arrange, authorize or deny transportation services. Brokers decide the form of transportation a client receives.

Brokers are expected to verify the client's eligibility in the Department database and to authorize or deny the transportation request based on whether it is medically necessary. Brokers are responsible for contracting with transportation providers. The brokers keep all documentation to support eligibility determinations; the providers keep documentation supporting the trip.

It is the responsibility of the Department to monitor the brokers to ensure they and the providers comply with federal and state Medicaid regulations and that transportation services are legitimate, allowable, reasonable and adequately supported.

During the fiscal year 2008 audit, we reported a finding on the Department's inadequate monitoring of brokers.

The state now has eight brokers in 13 regions and spent approximately \$79 million on the program in fiscal year 2009. This is an increase of \$11 million over the previous one-year period.

Description of Condition

The Department disagreed with the finding and has made no improvements in monitoring brokers to ensure all Medicaid rules are followed and costs are appropriate.

Cause of Condition

The Department stated it relies on the belief that brokers comply with the terms of the contracts.

Effect of Condition

To find out the overall effects of the Department's lack of monitoring we selected two brokers, based on how much was paid to them, for a more detailed examination.

We selected 157 payments totaling \$56,750.70 and found:

- **Reasonableness of rates**
Brokers are responsible for approving rates proposed by providers. The Department has no role in rate-setting, resulting in the inability to ensure rates are reasonable and competitive.

During our testing we identified five instances totaling \$358 in which a provider was paid more than \$70 each way for trips ranging from one to two miles.
- **Payments for services not fully supported**
Brokers pay providers based on expenditures they report each month. Providers submit supporting documentation only when asked. We selected 146 payments totaling \$53,585.63 and found 60 that were not supported by driver logs. This includes:
 - 40 payments resulting in an underpayment of 1,657.31.
 - 18 payments resulting in an overpayment of \$998.97.
- **Cost-effective transportation not provided**
Brokers are required to choose the most cost-effective mode of transportation while still accommodating the clients' needs. Six trips totaling \$2,807.07 were performed using a costly mode of transportation when a more cost-effective method was available. For example, a provider used a ferry when travel by car would have been a less expensive alternative.

Without adequate monitoring, the Department cannot ensure **non-emergency medical transportation expenditures are legitimate, reasonable and adequately supported.**

Recommendation

We recommend the Department establish a process for monitoring broker contracts to ensure all Medicaid rules are followed and services the brokers provided are legitimate, allowable, reasonable and supported.

Department's Response

The Department does not concur with this finding.

The following are the Department's responses to the specific areas of concerns raised in this finding:

- *The Department disagrees that it has a non-participatory role in rate-setting. The current contract requires brokers to obtain the best rates in a competitive marketplace to ensure access to these services throughout the state, and to develop a competitive marketplace that has a variety of providers for each mode of transportation. The Department and the brokers periodically complete Request for Procurement to develop the marketplace and ensure rates are reasonable and competitive.*
- *The Department does require providers to retain all supporting "trip" documentation and to provide this documentation for program review and monitoring as requested. Brokers may have an electronic or manual/paper billing system. If brokers have an electronic billing system, then the transportation provider submits required data elements as part of the electronic billing. Brokers with a manual/paper-process billing system receive supporting paper documentation as part of the invoice process. Brokers are expected to review monthly billings and audit transportation provider claims. Under and overpayments,*

for example, would be investigated further and additional documentation (such as written drivers logs or manifests) required.

- *The Department disagrees that payments for services were not fully supported based upon an initial review of just a portion of the trip data provided by SAO. Potential problems were located with the methodology and accounting utilized by SAO, including:*
 - *An inflated statement of the overpayment rate for ferries cost;*
 - *Errors utilized in accounting for drivers lunch time and breaks; and*
 - *Accounting discrepancies located in trip data.*

- *Brokers are required to choose the most cost-effective mode of transportation while still accommodating the client's medical condition and needs. A client's needs sometimes dictate a more expensive trip than a less expensive trip. There are instances in which having a client endure a longer car ride may not be in the best medical interests of the client. For instance, a broker may make the decision that is more appropriate to transport a client via ferry to avoid a longer trip driving around Puget Sound for a client who recently had complex surgeries or been treated for traumatic injuries.*

In late 2008, the Health and Recovery Services Administration (HRSA) submitted a state plan amendment to the Centers for Medicare and Medicaid Services (CMS) requesting approval to move these costs from administrative match to medical match which will not only better leverage federal dollars but will also align the program monitoring. The Department expects CMS approval within the next few months. In addition, the Department has plans for both desk and onsite audits to be performed by the Department's Office of Program Integrity to strengthen the oversight function.

Auditor's Remarks

We appreciate the Department's comments. Under the brokerage transportation system, brokers determine allowability of expenditures and receive administrative fees plus reimbursements for direct trip costs. Without proper fiscal monitoring of brokers the Department cannot ensure all expenditures are allowable and supported. During the audit, we found the Department did not perform fiscal monitoring of brokers. Our on-site testing at two brokers revealed the effects of the Department's lack of monitoring. Some transportation payments are not reasonable or fully supported and the most cost-effective mode of transportation is not always used. We will review this area during our next audit.

Applicable Laws and Regulations

Circular No. A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Subpart C, §_300 Auditee responsibilities. states in part:

The auditee shall:

- (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.

OMB Circular A-87: *Cost Principles for State, Local and Indian Tribal Governments*; Attachment A - *General Principles for Determining Allowable Costs*; Section C - *Basic Guidelines* state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:

C. Basic Guidelines

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
 - a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.

- b. Be allocable to Federal awards under the provisions of 2 CFR part 225.
 - c. Be authorized or not prohibited under State or local laws or regulations.
 - d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
 - e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.
 - f. Be accorded consistent treatment. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Federal award as an indirect cost.
 - g. Except as otherwise provided for in 2 CFR part 225, be determined in accordance with generally accepted accounting principles.
 - h. Not be included as a cost or used to meet cost sharing or matching requirements of any other Federal award in either the current or a prior period, except as specifically provided by Federal law or regulation.
 - i. Be the net of all applicable credits.
 - j. Be adequately documented.
2. Reasonable costs. A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. The question of reasonableness is particularly important when governmental units or components are predominately federally-funded. In determining reasonableness of a given cost, consideration shall be given to:
- a. Whether the cost is of a type generally recognized as ordinary and necessary for the operation of the governmental unit or the performance of the Federal award.
 - b. The restraints or requirements imposed by such factors as: Sound business practices; arm's-length bargaining; Federal, State and other laws and regulations; and, terms and conditions of the Federal award.
 - c. Market prices for comparable goods or services.
 - d. Whether the individuals concerned acted with prudence in the circumstances considering their responsibilities to the governmental unit, its employees, the public at large, and the Federal Government.
 - e. Significant deviations from the established practices of the governmental unit which may unjustifiably increase the Federal award's cost.

WAC 388-546-5100 Nonemergency transportation program scope of coverage

- (1) The department's health and recovery services administration (HRSA) covers transportation that is necessary for its clients to receive medically necessary HRSA covered services. See WAC [388-546-0100](#) through [388-546-1000](#) for Ambulance transportation that covers emergency ambulance transportation and limited nonemergency ground ambulance transportation as medical services.
- (2) Licensed ambulance providers, who contract with HRSA's transportation brokers, may be reimbursed for nonemergency transportation services under WAC [388-546-5200](#) as administrative services.
- (3) HRSA covers nonemergency transportation under WAC [388-546-5000](#) through [388-546-5500](#) as an administrative service as provided by the Code of Federal Regulations (42 CFR 431.53 and 42 CFR 440.170 (a)(2)). As a result, clients may not select the transportation provider(s) or the mode of transportation (service mode).
- (4) Prior authorization by HRSA is required for all out-of-state nonemergency transportation. Border areas as defined by WAC [388-501-0175](#) are considered in-state under this section and subsequent sections.
 - (a) HRSA reviews requests for out-of-state nonemergency transportation in accordance with regulations for covered healthcare services, including WAC [388-501-0180](#), [388-501-0182](#) and [388-501-0184](#).

- (b) Nonemergency transportation is not provided to or from locations outside of the United States and U.S. territories, except for the limitations for British Columbia, Canada, identified in WAC [388-501-0184](#)
- (5) HRSA requires all nonemergency transportation to and from covered services to meet the following:
 - (a) The covered service must be medically necessary as defined in WAC [388-500-0005](#);
 - (b) It must be the lowest cost available service mode that is both appropriate and accessible to the client's medical condition and personal capabilities; and
 - (c) Be limited to the local provider of type as follows:
 - (i) Clients receiving services provided under HRSA's fee-for-service program may be transported only to the local provider of type. HRSA's transportation broker is responsible for considering and authorizing exceptions.
 - (ii) Clients enrolled in HRSA's managed care (healthy options) program may be transported to any provider supported by the client's managed care plan. Clients may be enrolled in a managed care plan but are obtaining a specific service not covered under the plan. The requirements in subsection (5)(c)(i) apply to these fee-for-service services.
- (6) HRSA does not cover nonemergency transportation services if the covered medical services are within three-quarters of a mile walking distance from the client's residence. Exceptions to this rule may be granted by HRSA's transportation broker based on the client's documented medical condition or personal capabilities, or based on safety or physical accessibility concerns, as described in WAC [388-546-5400\(1\)](#).
- (7) A client must use personal or informal transportation alternatives if they are available and appropriate to the client's needs.
- (8) If a fixed-route public transportation service is available to the client within three-quarters of a mile walking distance, the broker may require the client to use the fixed-route public transportation system unless the need for more specialized transportation is present and documented. Examples of such a need are the client's use of a portable ventilator, a walker or a quad cane.
- (9) HRSA does not cover any nonemergency transportation service that is not addressed in WAC [388-546-1000](#) or in 388-546-5000 through 388-546-5500. See WAC [388-501-0160](#) for information about obtaining approval for noncovered transportation services, known as exception to rule (ETR).
- (10) If a medical service is approved by ETR, both the broker and MAA must separately prior approve transportation to that service.
- (11) HRSA may exempt members of federally recognized Indian tribes from the brokered transportation program. Where HRSA approves the request of a tribe or a tribal agency to administer or provide transportation services under WAC [388-546-5000](#) through [388-546-5400](#), tribal members obtain their transportation services as provided by the tribe or tribal agency.
- (12) A client who is denied service under this chapter may request a fair hearing per chapter [388-02](#) WAC.

WAC 388-546-5200 Nonemergency transportation program broker and provider requirements.

- (1) MAA requires that all nonambulance transportation providers serving MAA clients be under subcontract with the department's contracted transportation broker. MAA's transportation brokers may subcontract with ambulance providers for nonemergency trips in licensed ground ambulance vehicles as administrative services. See WAC [388-546-5100\(2\)](#).
- (2) MAA requires all contracted and subcontracted transportation providers under this chapter to be licensed, equipped, and operated in accordance with applicable federal, state, and local laws.
- (3) MAA's transportation brokers determine the level of transportation service needed by the client and the mode of transportation to be used for each authorized trip.
- (4) MAA's transportation brokers must comply with the terms specified in their contracts.
- (5) MAA's transportation brokers may require up to forty-eight hours advance notice of a requested trip (see WAC [388-546-5300\(2\)](#)) with the exception of hospital requests or urgent care trips. MAA allows its transportation brokers to accommodate requests that provide less than forty-eight hours advance notice, within the limits of the resources available to a broker at the time of the request.
- (6) If MAA's transportation broker is not open for business and unavailable to give advance approval for a hospital discharge or urgent care request as described in subsection (5), the subcontracted transportation provider must either:

- (a) Provide the transportation in accordance with the broker's instructions and request an after-the-fact authorization from the transportation broker within seventy-two hours of the transport; or
 - (b) Deny the transportation, if the requirements of this section cannot be met.
- (7) If the subcontracted transportation provider provides transportation as described in subsection (6), the broker may agree to grant retroactive authorization as provided in WAC 388-546-5300(3). Such retroactive authorization must be:
- (a) Documented as to the reasons retroactive authorization is needed; and
 - (b) Agreed to by the broker within seventy-two hours after the transportation to a medical appointment.
- (8) MAA, through its transportation brokers, does not pay for transportation under the following conditions:
- (a) Clients are not eligible for transportation services when medical services are within reasonable walking distance (normally three-quarters of a mile actual traveling distance), taking into account the client's documented medical condition and personal capabilities (see WAC 388-546-5100(6));
 - (b) Clients must use personal or informal transportation alternatives if they are available and appropriate to the clients' needs (see WAC 388-546-5100(7));
 - (c) If a fixed-route public transportation service is available to the client within three-quarters of a mile walking distance, the broker may require the client to use the fixed route public transportation under the terms of WAC 388-546-5100(8);
 - (d) MAA or MAA's transportation broker may deny transportation services requested if the request is not necessary, suitable, or appropriate to the client's medical condition (see WAC 388-546-5100(1) and (5)(a));
 - (e) The medical services requiring transportation must be services that are covered by the client's medical program (see WAC 488-546-5100(1)); or
 - (f) The transportation selected by the broker for the client must be the lowest cost available alternative that is both appropriate and accessible to the client's medical condition and personal capabilities.
 - (9) The transportation broker mails a written notice of denial to each client who is denied coverage of transportation within three business days of the denial.

WAC 388-546-5300 Nonemergency transportation program client requirements.

- (1) Clients must be compliant with MAA's transportation brokers, the brokers' subcontracted transportation providers, and MAA's medical services providers. A client who is in noncompliance may have limited transportation service mode options available. The broker mails the client a written notice of limited transportation service mode options within three business days of the broker's decision that transportation service mode options are limited.
- (2) Clients must request, arrange and obtain authorization for transportation forty-eight hours in advance of a medical appointment. Exceptions to the forty-eight-hour advance arrangements are described in subsection (3) of this section and in WAC 388-546-5200(5) and (6).
- (3) If MAA's contracted broker is not open for business at the time nonemergency transportation is needed, the client must follow the transportation broker's instructions to obtain transportation service.
- (4) MAA will cover a clients transportation to medically necessary covered services with local providers of type. Transportation services will be covered to nonlocal providers of type in the following circumstances:
 - (a) The client is enrolled in a healthy options managed health care plan and the client's primary care provider (PCP) or a PCP referred provider is not the closest available provider;
 - (b) The client's service is covered by a third party payer and the payer requires or refers the client to a specific provider;
 - (c) A charitable or other voluntary program (e.g., Shriners) is paying for the client's medical service;
 - (d) The medical service required by the client is not available within the local healthcare service area;
 - (e) The total cost to MAA is lower when the services are obtained outside of the local healthcare service area; or

- (f) The out-of-area service is required to provide continuity of care for the client's ongoing care as:
 - (i) Documented by the client's primary care provider; and
 - (ii) Agreed to by MAA's contracted transportation broker.
- (5) MAA may require transportation brokers to refer any of the exception categories listed in subsection (4) to MAA's medical director or the medical director's designee for review and/or prior authorization of the medical service.
- (6) If local medical services are not available to a client because of noncompliance with MAA's transportation brokers, the brokers' subcontracted transportation providers, or MAA's medical services providers, MAA does not cover nonemergency transportation to out-of-area medical services for the client. MAA's contracted broker mails a written notice to the client within three business days of the broker's determination that the client's documented noncompliance results in a denial to out-of-area transportation services.

WAC 388-546-5400 Nonemergency transportation program general reimbursement limitations.

- (1) To be reimbursed, MAA requires that a trip be a minimum of three-quarters of a mile from pick-up point to drop off point (see WAC [388-546-5100\(6\)](#)). MAA's transportation broker may grant exceptions to the minimum distance requirement for any of the following conditions:
 - (a) When there is medical justification for a shorter trip;
 - (b) When the trip involves an area that MAA's contracted broker considers to be unsafe for the client, other riders, or the driver; or
 - (c) When the trip involves an area that the broker determines is not physically accessible to the client.
- (2) MAA reimburses for return trips from covered medical services if the return trips are directly related to the original trips. MAA, through its transportation broker, may deny coverage of a return trip if any delays in the return trip are for reasons not directly related to the original trip.
- (3) MAA does not reimburse any costs related to intermediate stops that are not directly related to the original approved trip.
- (4) MAA's transportation broker may authorize intermediate stops that are directly related to the original approved trip if the broker determines that the intermediate stop is likely to limit or eliminate the need for supplemental covered trips. MAA considers the following reasons to be related to the original trip:
 - (a) Transportation to and from an immediate subsequent medical referral; or
 - (b) Transportation to a pharmacy to obtain one or more prescriptions when the pharmacy is within a reasonable distance of the original medical appointment route.
- (5) MAA may pay the costs of meals and lodging for clients who must be transported to out-of-area medical services. MAA's transportation brokers make the determination that meals and lodging are necessary based on client need and the reasonableness of costs (as measured against state per diem rates).
- (6) MAA may pay transportation costs, including meals and lodging, for authorized escorts. MAA's transportation brokers make the determination that the costs of escorts are necessary based on client need and reasonableness of costs (as measured against state per diem rates).
- (7) MAA does not provide escorts or pay the wages of escorts. MAA does not pay for the transportation of an escort when the client is not present unless the broker documents exceptional circumstances causing the broker to determine that the service is necessary to ensure that the client has access to medically necessary care.
- (8) MAA may reimburse for the transportation of a guardian with or without the presence of the client if the broker documents its determination that such a service is necessary to ensure that the client has access to medically necessary care.

WAC 388-546-5500 Modifications of privately owned vehicles.

- (1) MAA may cover and reimburse the purchase of vehicle driving controls, a vehicle wheelchair lift conversion, or the purchase or repair of a vehicle wheelchair lift, when:
 - (a) The requested item is necessary for the client's transportation to medically necessary MAA-covered services; and
 - (b) The client owns a vehicle that MAA determines is suitable for modification; and

- (c) Medical transportation provided under WAC 388-546-5000 through 388-546-5400 cannot meet the client's need for transportation to and from medically necessary covered services at a lower total cost to the department (including anticipated costs); and
 - (d) Prior approval from MAA is obtained.
- (2) Any vehicle driving controls, vehicle wheelchair lift conversion or vehicle wheelchair lift purchased by MAA under this section becomes the property of the client on whose behalf the purchase is made. MAA assumes no continuing liability associated with the ownership or use of the device.
 - (3) MAA limits the purchase of vehicle driving control(s), vehicle wheelchair lift conversion or vehicle wheelchair lift to one purchase per client. If a device purchased under this section becomes inoperable due to wear or breakage and the cost of repair is more than the cost of replacement, MAA will consider an additional purchase under this section as long as the criteria in subsection (1) of this section are met.
 - (4) MAA must remain the payer of last resort under this section.
 - (5) MAA does not cover the purchase of any new or used vehicle under this section or under this chapter.

09-32 The Department of Social and Health Services, Health and Recovery Services Administration’s, internal controls are inadequate to ensure controlled substances prescribed for Medicaid clients are authorized and allowable.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care Providers and Suppliers
93.778 Medical Assistance Program (Medicaid; Title XIX)
93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment (ARRA)
Federal Award Number: 5-0905WA5028, 5-0905W5048, 5-0905WAARRA
Applicable Compliance Component: Activities Allowed/Unallowed, Allowable Costs/Cost Principles
Questioned Cost Amount: \$84,046.47

Background

All controlled substances are classified as scheduled drugs ranging from level 1-5; the number represents the potential risk of abuse the drug poses to the client. Schedule 1 drugs, such as heroin, are illegal. The rest are considered legitimate for medical use, and range from drugs such as morphine (schedule 2), to cough syrup with codeine (schedule 5).

Individuals who prescribe controlled substances are required by federal regulations to register with the Drug Enforcement Administration (DEA). These individuals must have an active medical license in the state in which they practice. The purpose of this registration is to track all prescribers of controlled substances in a national database and to have the ability to monitor all prescriptions. When an individual registers with the DEA, he or she is authorized to prescribe or dispense controlled substances and assigned a DEA identification number.

In our audit for fiscal year 2008, we reported a finding related to the Department’s inadequate controls over schedule 3-5 drugs. The Department only validated DEA numbers of prescribers who prescribe schedule 2 drugs.

The Department paid \$34,373,102.34 in claims for schedule 2 through 5 drugs between July 1, 2008 and June 30, 2009. As a result of the American Recovery and Reinvestment Act of 2009 implemented in October 2008, the expenditures for controlled substances previously federally funded at approximately 50 percent would now be eligible for funding at over 60 percent.

Also in October of 2008, the Department began using the ProviderOne point-of-sale system, taking the place of the previous system used to process prescription drug claims submitted by pharmacies.

Description of Condition

The Department disagreed with our finding and made no changes to address our concerns. In fact, after the deployment of ProviderOne in October 2008, the system no longer automatically validates the DEA numbers for schedule 2 drugs. As a result, the Department did not validate any DEA numbers of prescribers of schedule 2-5 drugs.

Cause of Condition

The Department stated it is not responsible for verifying DEA numbers of prescribing physicians. It believes this responsibility lies with medical licensing authorities and the dispensing pharmacies.

Effect of Condition

During our audit, we identified 8,612 pharmacy claims for scheduled drugs 2-5 representing a total of \$137,906.63 that were paid without the claim including a valid DEA number. This includes:

Schedule 2	\$55,865.11
Schedule 3	\$28,212.88
Schedule 4	\$38,904.31
Schedule 5	\$14,924.33

We are questioning \$84,046.47 which is the federal portion of the expenditures.

Without procedures in place to verify prescribers are legally authorized to prescribe scheduled drugs, the Department cannot ensure claims paid are allowable expenditures of Medicaid funds.

Recommendation

We recommend the Department establish and follow internal controls that will reasonably ensure prescribers of controlled substances have valid DEA numbers that demonstrate they are authorized to provide this service in accordance with federal requirements.

Department's Response

The Department does not concur with this finding.

There are no federal or state statutes that require a payer (e.g. state) to validate the Drug Enforcement Administration (DEA) number of a prescriber. Therefore, the Department disagrees that the lack of an edit that validates DEA for Schedule 2-5 drugs constitutes inadequate internal controls or that the lack of such validation renders the payment unallowable.

The Department believes that responsibility for compliance with controlled substance requirements lies with the prescribing provider and the dispensing pharmacies. There are no provisions in the Controlled Substance Act (21 USC Sec. 821) or the State Uniform Controlled Substance Act (RCW 69.50) that could be interpreted as a requirement relating to payment of claims for controlled substances. Below is the Title 21 CFR Section 1306.04 which clearly states that the prescribing practitioner is responsible for assuring that the prescription conforms in all essential respects to the law and regulation:

(a) A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of section 309 of the Act (21 USC 829) and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances."

The Controlled Substances Act (CSA) is the federal drug policy under which the manufacture, importation, possession and distribution of certain drugs is regulated. Classification decisions are made on the criteria of potential for abuse, accepted medical use in the United States and potential for drug dependence. Registration with the DEA authorizes a pharmacy to sell controlled substances and allows for a method of monitoring who is selling potentially addictive drugs. The CSA does not regulate payment for controlled substances.

The Department implemented a Pharmacy Point of Sale (POS) edit in July 2002 for the purpose of validating the DEA of the prescribing physician for Schedule II drugs. While the Department considered this to be an essential validation to add to the POS, it was not implemented because of any federal/state requirement. Rather, the Department implemented this because Schedule II drugs are subject to the highest risk of abuse and considered it prudent to provide this additional validation to guard against the potential for fraud and abuse.

At implementation of the new Pharmacy POS in October 2008, the prescriber identifier changed to the National Provider Identifier (NPI). This change caused the POS to experience some difficulty with the Schedule II system edit due to the incomplete nature of the association between NPI and DEA. No comprehensive national file exists which can be used to crosswalk all NPI to DEA. While the POS continues to validate DEA numbers for Schedule II drugs, a Change Request is currently in process to complete implementation of a comprehensive NPI to DEA association crosswalk and to add DEA effective date spans to the file.

A detailed review of the specific claim findings yielded the following information:

- *Invalid DEA: (236 unique DEA). The Department reviewed each unique DEA. All but one is currently active in the POS system. Discrepancies in DEA validation are due to the use of different DEA sources. In previous years, direct inquiries to DEA have in fact yielded different answers for specific DEA. While the POS does not currently accommodate DEA effective date spans, each of these DEA were reviewed and 235 of 236 were valid in the POS for the claim date of service.*
- *DSHS ID: (27 unique numbers): None of the associated claims are for Schedule II drugs and all are prior to the cutover to the new POS (October 2008). In the legacy POS, Billing Instructions required either DEA or DSHS Provider ID for use in the prescriber field. These claims were appropriately billed with DSHS Provider ID.*
- *Blank (7,154 claims): DSHS reviewed a sample of these claims in the POS system and they all appeared in POS with valid prescriber NPI with associated DEA. Implementation of the new POS allowed NPI to be submitted as the prescriber identified. However, the legacy MMIS cannot accommodate the NPI. Since Medicaid data supplied to SAO came from the MMIS, these fields are appearing as blank in the data, but a valid DEA is present in the POS.*

In addition to the POS edit that validates the DEA for Schedule II drugs, DSHS has a set of robust Program Integrity activities including pharmacy utilization review, pharmacy rules-based algorithms that identify improper payments, and data mining activities that identify patterns outside the norm. In the absence of any requirement to validate DEA for controlled substances, DSHS considers that this set of Program Integrity activities provide adequate controls to ensure that controlled substances are authorized and allowable.

Auditor's Remarks

We thank the Department for its response. We agree the Department does not have a regulatory role over controlled substance prescribers. However, the Department does have a responsibility to ensure that services provided to Medicaid clients are allowable. In order for controlled substances to be an allowable Medicaid service, those substances must be prescribed by a provider with a valid DEA number. The Department was not able to provide any evidence that providers who prescribed controlled substances for the expenditures we questioned had valid DEA numbers. We will review this area during our next audit.

Applicable Laws and Regulations

Circular No. A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Subpart C, §_300 Auditee responsibilities. states in part:

The auditee shall:

- (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.

OMB Circular A-87: Cost Principles for State, Local and Indian Tribal Governments; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
 1. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.

2. Be allocable to Federal awards under the provisions of 2 CFR part 225.
3. Be authorized or not prohibited under State or local laws or regulations.
4. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
5. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.
6. Be accorded consistent treatment. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Federal award as an indirect cost.
7. Except as otherwise provided for in 2 CFR part 225, be determined in accordance with generally accepted accounting principles.
8. Not be included as a cost or used to meet cost sharing or matching requirements of any other Federal award in either the current or a prior period, except as specifically provided by Federal law or regulation.
9. Be the net of all applicable credits.
10. Be adequately documented.

Title 21, code of Federal Regulations, Section 1306 states in part:

1306.03 Persons entitled to issue prescriptions.

- (a) A prescription for a controlled substance may be issued only by an individual practitioner who is:
 - (1) Authorized to prescribe controlled substances by the jurisdiction in which he is licensed to practice his profession and
 - (2) Either registered or exempted from registration pursuant to §§1301.22(c) and 1301.23 of this chapter.
- (b) A prescription issued by an individual practitioner may be communicated to a pharmacist by an employee or agent of the individual practitioner.

§ 1306.21 Requirement of prescription.

- (a) A pharmacist may dispense directly a controlled substance listed in Schedule III, IV, or V which is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act, only pursuant to either a written prescription signed by a practitioner or a facsimile of a written, signed prescription transmitted by the practitioner or the practitioner's agent to the pharmacy or pursuant to an oral prescription made by an individual practitioner and promptly reduced to writing by the pharmacist containing all information required in §1306.05, except for the signature of the practitioner.
- (b) An individual practitioner may administer or dispense directly a controlled substance listed in Schedule III, IV, or V in the course of his/her professional practice without a prescription, subject to §1306.07.
- (c) An institutional practitioner may administer or dispense directly (but not prescribe) a controlled substance listed in Schedule III, IV, or V only pursuant to a written prescription signed by an individual practitioner, or pursuant to a facsimile of a written prescription or order for medication transmitted by the practitioner or the practitioner's agent to the institutional practitioner-pharmacist, or pursuant to an oral prescription made by an individual practitioner and promptly reduced to writing by the pharmacist (containing all information required in Section 1306.05 except for the signature of the individual practitioner), or pursuant to an order for medication made by an individual practitioner which is dispensed for immediate administration to the ultimate user, subject to §1306.07.

§ 1306.22 Refilling of prescriptions.

- (a) No prescription for a controlled substance listed in Schedule III or IV shall be filled or refilled more than six months after the date on which such prescription was issued and no such prescription authorized to be refilled may be refilled more than five times. Each refilling of a prescription shall be entered on the back of the prescription or on another appropriate document. If entered on another document, such as a medication record, the document must be uniformly maintained and readily retrievable. The following information must be retrievable by the prescription number consisting of the

name and dosage form of the controlled substance, the date filled or refilled, the quantity dispensed, initials of the dispensing pharmacist for each refill, and the total number of refills for that prescription. If the pharmacist merely initials and dates the back of the prescription it shall be deemed that the full face amount of the prescription has been dispensed. The prescribing practitioner may authorize additional refills of Schedule III or IV controlled substances on the original prescription through an oral refill authorization transmitted to the pharmacist provided the following conditions are met:

- (1) The total quantity authorized, including the amount of the original prescription, does not exceed five refills nor extend beyond six months from the date of issue of the original prescription.
 - (2) The pharmacist obtaining the oral authorization records on the reverse of the original prescription the date, quantity of refill, number of additional refills authorized, and initials the prescription showing who received the authorization from the prescribing practitioner who issued the original prescription.
 - (3) The quantity of each additional refill authorized is equal to or less than the quantity authorized for the initial filling of the original prescription.
 - (4) The prescribing practitioner must execute a new and separate prescription for any additional quantities beyond the five refill, six-month limitation.
- (b) As an alternative to the procedures provided by subsection (a), an automated data processing system may be used for the storage and retrieval of refill information for prescription orders for controlled substances in Schedule III and IV, subject to the following conditions:
- (1) Any such proposed computerized system must provide on-line retrieval (via CRT display or hard-copy printout) of original prescription order information for those prescription orders which are currently authorized for refilling. This shall include, but is not limited to, data such as the original prescription number, date of issuance of the original prescription order by the practitioner, full name and address of the patient, name, address, and DEA registration number of the practitioner, and the name, strength, dosage form, quantity of the controlled substance prescribed (and quantity dispensed if different from the quantity prescribed), and the total number of refills authorized by the prescribing practitioner.
 - (2) Any such proposed computerized system must also provide on-line retrieval (via CRT display or hard-copy printout) of the current refill history for Schedule III or IV controlled substance prescription orders (those authorized for refill during the past six months.) This refill history shall include, but is not limited to, the name of the controlled substance, the date of refill, the quantity dispensed, the identification code, or name or initials of the dispensing pharmacist for each refill and the total number of refills dispensed to date for that prescription order.
 - (3) Documentation of the fact that the refill information entered into the computer each time a pharmacist refills an original prescription order for a Schedule III or IV controlled substance is correct must be provided by the individual pharmacist who makes use of such a system. If such a system provides a hard-copy printout of each day's controlled substance prescription order refill data, that printout shall be verified, dated, and signed by the individual pharmacist who refilled such a prescription order. The individual pharmacist must verify that the data indicated is correct and then sign this document in the same manner as he would sign a check or legal document (e.g., J. H. Smith, or John H. Smith). This document shall be maintained in a separate file at that pharmacy for a period of two years from the dispensing date. This printout of the day's controlled substance prescription order refill data must be provided to each pharmacy using such a computerized system within 72 hours of the date on which the refill was dispensed. It must be verified and signed by each pharmacist who is involved with such dispensing. In lieu of such a printout, the pharmacy shall maintain a bound log book, or separate file, in which each individual pharmacist involved in such dispensing shall sign a statement (in the manner previously described) each day, attesting to the fact that the refill information entered into the computer that day has been reviewed by him and is correct as shown. Such a book or file must be maintained at the pharmacy employing such a system for a period of two years after the date of dispensing the appropriately authorized refill.
 - (4) Any such computerized system shall have the capability of producing a printout of any refill data which the user pharmacy is responsible for maintaining under the Act and its implementing regulations. For example, this would include a refill-by-refill audit trail for any specified strength and dosage form of any controlled substance (by either brand or generic name or both). Such a printout must include name of the prescribing practitioner, name and address of the patient, quantity dispensed on each refill, date of dispensing for each refill,

name or identification code of the dispensing pharmacist, and the number of the original prescription order. In any computerized system employed by a user pharmacy the central recordkeeping location must be capable of sending the printout to the pharmacy within 48 hours, and if a DEA Special Agent or Diversion Investigator requests a copy of such printout from the user pharmacy, it must, if requested to do so by the Agent or Investigator, verify the printout transmittal capability of its system by documentation (e.g., postmark).

- (5) In the event that a pharmacy which employs such a computerized system experiences system down-time, the pharmacy must have an auxiliary procedure which will be used for documentation of refills of Schedule III and IV controlled substance prescription orders. This auxiliary procedure must insure that refills are authorized by the original prescription order, that the maximum number of refills has not been exceeded, and that all of the appropriate data is retained for on-line data entry as soon as the computer system is available for use again.
- (c) When filing refill information for original prescription orders for Schedule III or IV controlled substances, a pharmacy may use only one of the two systems described in paragraphs (a) or (b) of this section.

§ 1306.23 Partial filling of prescriptions.

The partial filling of a prescription for a controlled substance listed in Schedule III, IV, or V is permissible, provided that:

- (a) Each partial filling is recorded in the same manner as a refilling,
- (b) The total quantity dispensed in all partial fillings does not exceed the total quantity prescribed, and
- (c) No dispensing occurs after 6 months after the date on which the prescription was issued.

Section 1301.11 Persons required to register.

- (a) Every person who manufactures, distributes, dispenses, imports, or exports any controlled substance or who proposes to engage in the manufacture, distribution, dispensing, importation or exportation of any controlled substance shall obtain a registration unless exempted by law or pursuant to Secs. [1301.22-1301.26](#). Only persons actually engaged in such activities are required to obtain a registration; related or affiliated persons who are not engaged in such activities are not required to be registered. (For example, a stockholder or parent corporation of a corporation manufacturing controlled substances is not required to obtain a registration.)
- (b) [Reserved]